DEPT.- 65

JOB- 21

REEL- 39

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

VP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23007

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48216

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Schaeffer

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1838 Aug 7th

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital

NOV 20 1920 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1913 to November 18 1920 that I last saw her alive on November 18, 1920 and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) W. H. Herman, M. D.

11/19/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 20 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 603 N Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48217

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2209 Wilkens Ave ST.: 20 WARD)

2-FULL NAME Mary Elizabeth Rigby

(a) RESIDENCE. NO. 2209 Wilkens Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeremiah Oliver Rigby

6 DATE OF BIRTH (month, day, and year) March 16 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ....."

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Allen Mills.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Etta Parks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Charles M. Berry. (Address) 2209 Wilkens ave.

NOV 20 1920

Robert F. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18 1920.

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov 18th, 1920, that I last saw h.. alive on Nov 18, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

~~Contributory~~ Arteio Sclerosis.

Chronic Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrhage

(duration) yrs. mos. 1/2 hour. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) William Michel, M. D.

Nov 19. 1920 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 22 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1005 Balto St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN: Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48218 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48218

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 544 W Mulberry St.: 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Boozer

(Residence in Baltimore: No. 544 W. Mulberry St St.: 20 yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	Married

6-DATE OF BIRTH, Don't Know, 1880
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Boozer

(Address) 421 N. Gardner St

15-

NOV 20 1920 (Date) Robert P. Harrison, By
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic disease of the Heart a number of years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know if any

(Duration) yrs. mos. ds.

(Signed) W. H. Forsyth M. D.
(Coroner.)

11-18, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov 21, 1920
20-UNDERTAKER Chas G Bailey	ADDRESS 1421 Jefferson St

Nos. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48219 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48219

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 1405 E Eager ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia J. Hanlon

(a) RESIDENCE. NO. 1405 E Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Hanlon

6 DATE OF BIRTH (month, day, and year) Sept 18 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Martin Swerdling

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Schwartz.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mr John J. Hanlon
(Address) 1405 E Eager st

15 Filed NOV 20 1920 Robert P. Harrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/26, 1920, to 11/19, 1920, that I last saw h alive on 11/18, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

about 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 6 Wks

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Dr Bernard Wolff M. D.

11/20 1920 (Address) 904 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 22 1920
20 UNDERTAKER Henry Horsch Son	ADDRESS 30 E Eager st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48220

HEALTH DEPARTMENT--CITY OF BALTIMORE

20.48220

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 N. Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Baron

(a) RESIDENCE. NO. 1324 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward A. Baron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret E. Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Margaret E. Baron
(Address) 1324 N Broadway

15 Filed NOV 20 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 , 1920 , to Nov 19 , 1920 ,
that I last saw her alive on Nov 19 1920,
and that death occurred, on the date stated above, at 12 20 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exanition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo F Taylor , M. D.

11-21 19 20 (Address) 1257 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 22 1920
20 UNDERTAKER Henry Hoerl Son	ADDRESS 1301 E Eager

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.48221 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48221

CERTIFICATE OF DEATH. 37

REGISTERED NO...

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Eolaw Gt. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Robinson

(a) RESIDENCE. No. 1034 Eolaw Gt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18 1889

7 AGE: Years 31 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Balt Md

(c) Name of employer: Meds

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Ida Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jno Hall

(Address) 1034 Eolaw Ct

NOV 20 1920

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 1920, to Nov 18, 1920, that I last saw h alive on Nov 18, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Stenosis
Unknown Origin

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 21 1920

20 UNDERTAKER: Brosius & Friedlander — ADDRESS 1140 Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48222

CERTIFICATE OF DEATH.

47

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Kenwood Ave. St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Hilbert Sauer

(Residence in Baltimore: No. 506 N. Kenwood ave. St.; 27 yrs., 3 mos. 4 da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. (Month) 13 (Day), 1893 (Year)

7-AGE, 27 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Oil Maker

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Hilbert Sauer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Cath. Stenger

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Sauer

(Address) 506 N. Kenwood

15- NOV 20 1920, 191..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1920, to Nov. 18 1920, that I saw him alive on Nov 17 1920, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism -

Endocarditis.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) .....yrs. .....mos. .....ds.

(Signed) Wm J. Schmit M. D.

Nov 19, 1920 (Address) 701 N. Kenwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Redeemer	Nov. 22, 1920

20-UNDERTAKER	ADDRESS
Jos. J. Kerr	156 N. Eutaw Ave.

D.48223 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48223

CERTIFICATE OF DEATH.

174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospl ST.: 21 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy A Webbert

(Residence in Baltimore: No. 513 Calender St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 25 (Day), 1864 (Year)

7-AGE, 56 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinists
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE. (State or Country) Mechanicsburg Pa

PARENTS.

10-NAME OF FATHER, John Webbert

11-BIRTHPLACE OF FATHER (State or Country) Mechanicsburg Pa

12-MAIDEN NAME OF MOTHER Martha Zimmerman

13-BIRTHPLACE OF MOTHER (State or Country) Mechanicsburg Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Webbert

(Address) 732 W Fayette St

15- NOV 30 1920 Robert P. Harrison,

(Date), 191.. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: 0020

Traumatic Injury

Acc Compound Comm

Webbert (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H K Onion (Coroner) M. D.

11-E 31, 191.. (Address) 14 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	11/20, 19..
20-UNDERTAKER Robert Brookover	ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48224 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48224

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Drucilla Hodges

(a) RESIDENCE. No. 830 China St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress Off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Maryland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co. Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed NOV 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1920

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1920, to November 18, 1920, that I last saw her alive on November 18, 1920, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Chronic diffuse
nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) M. Evman. M. D.

11/19/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 21 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48225

CERTIFICATE OF DEATH.

X 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Cruikshank

(Residence in Baltimore: No. 100 Windsor Ave St.; ..... yrs., ... mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, ... (Month) ..... (Day) 1878 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own Acct

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Cruikshank

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Greenwood

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Cruikshank

(Address) 100 N. Eutaw St. Balto. Md.

15- NOV 20 1920 Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11/19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/11 1920, to 11/19 1920, that I saw h[e] alive on 11/19 1920, and that death occurred, on the date stated above, at 11.50 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion, Jaundice

..... (Duration) 6 yrs. ..... mos. 2 ds.

(Signed) Wm H Cline M. D.

11/17, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 100 Windsor Ave Md

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery. DATE OF BURIAL, Nov 22, 1920

20-UNDERTAKER C. M. Nagy ADDRESS Highland Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48226 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 Woodlawn Road St. 27 WARD) REGISTERED NO. C 100

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Napoleon Bonaparte Woolford

(Residence in Baltimore: No. 200 Woodlawn Road St.; 5+ yrs., mos., ds.)

Lives in Baltimore 55 yrs.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, about 2 (Month) (Day) 1842 (Year)

7-AGE 78 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession or particular kind of work Manufacturer of Lasts
(b) General nature of industry, business, or establishment in which employed (or employer) Oakum

9-BIRTHPLACE, (State or Country). Worchester Co. Md.

PARENTS.

10-NAME OF FATHER, James Woolford

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Anna Lecompt

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David N. Woolford

(Address) 200 Woodlawn Road

15- NOV 20 1920 Robert P. Harrison, 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov - 18 (Month) (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct - 20 1920, to Nov - 18 1920, that I saw h[im] alive on Nov - 18 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis +

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. — mos. 10 ds.

(Signed) M. Gibson Foley M. D.

Nov. 19, 1920 (Address) 422 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, 11/22, 1920

20-UNDERTAKER Henry W. Kears & Son — ADDRESS 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48227 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48227

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2132 Callow ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Cassel

(a) RESIDENCE. No. 2132 Callow ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Herman Cassel
(Address) 2132 Callow ave

15 Filed NOV 20 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 20, to ....., 19 ....., that I last saw h.. alive on Nov 19, 19 20, and that death occurred, on the date stated above, at 930 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) M Friedenwald, M. D.

, 19 (Address) 2328 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd. DATE OF BURIAL Nov. 21, 1920

20 UNDERTAKER J Levinson ADDRESS 1127 E Baltimore St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48228 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48228

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No U.S.P.H.S.Hospt #56, ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee J. Lewandowski

(a) RESIDENCE. No. 708 E. 23rd St., Erie, Pa. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PHYSICIANS should state EXACTLY the disease causing death. Every item of information should be stated EXACTLY in plain terms, so that it may be properly classified. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker 086

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward Rowbuck

(Address) Ft. McHenry, Balto. Md.

15 Nov 20 1920 19 Robert F. Harrison, Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1920

17 I HEREBY CERTIFY That I attended deceased from Nov. 10, 1920 to Nov. 19, 1920, that I last saw him alive on Nov. 19, 1920, 19..., and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic pulmonary (far advanced). Active pleurisy with effusion.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Thomas P. Payne, M. D. Surgeon (R

, 19 (Address) Ft. McHenry, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Erie Pa

DATE OF BURIAL Nov. 20 1920

20 UNDERTAKER J. Fuhrer & Bro

ADDRESS 1127 E Balto St

NOV 20 1920

Burial Permit Clerk

D.48229 HEALTH DEPARTMENT--CITY OF BALTIMORE D.48229

CERTIFICATE OF DEATH

89

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1753, Carlyle Place ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Susie Bagley

(Residence in Baltimore: No. 1753, Carlyle Place St.: 4 yrs. 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: November 17, ~~1887~~ 1920 (Month) (Day) (Year)

7 AGE: 33 yrs. 6 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Prince Edward County Virginia.

PARENTS

10 NAME OF FATHER: Henry Wallin.

11 BIRTHPLACE OF FATHER (State or country): Prince Edward County Virginia.

12 MAIDEN NAME OF MOTHER: Mary Fiske.

13 BIRTHPLACE OF MOTHER (State or country): Prince Edward County Virginia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Edward Bagley

(Address) 1753 Carlyle Place.

15 Filed NOV 20 1920, 19.. Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 19, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 28, 1920, to. Novembr 19 1920. that I saw her alive on November 18, 1920. and that death occurred. on the date stated above. at 1 P. m. The CAUSE OF DEATH* was as follows:

Acute Bronchitis.

coma

(Duration) ..... yrs. 2 mos. 19 ds

Contributory (SECONDARY) Heart Failure

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Frederick G. Roser M. D.

Nov 20, 1920 (Address) 102 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mehrrin Va. DATE OF BURIAL: Nov 22, 1920

20 UNDERTAKER: Chas. E. Biley ADDRESS: 1421 Jefferson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

5933-M

Spec.—6-9-19—H. P. Co.—1000 Blks.

948230 HEALTH DEPARTMENT—CITY OF BALTIMORE 948230

CERTIFICATE OF DEATH. X 74

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: [illegible] WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Ira L. Heikes.

(a) RESIDENCE. NO. Dillsburg Pennsylvania ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Mrs Elizabeth E Heikes

6 DATE OF BIRTH (month, day, and year) Oct 9-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Heikes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Louisa Cordelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) J. H. Beards

15 Filed NOV 21 1920 ROBERT E KRAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov 20, 1920, that I last saw h alive on Nov 20, 1920, and that death occurred, on the date stated above, at 12 15 p m.

The CAUSE OF DEATH* was as follows:

Obscure reaction following Cerebral Cyst.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of 11/18/20

Was there an autopsy? No.

What test confirmed diagnosis? X Ray

(Signed) M. K. Turnbull, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillsburg, Pa. DATE OF BURIAL Nov 20 1920

20 UNDERTAKER John O Mitchell ADDRESS 1201 N Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Should be carefully supplied. AGE should be stated EXACTLY. Every item of information it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

2048231

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048231

CERTIFICATE OF DEATH.

1492

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Madison ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Ginsberg

(Residence in Baltimore: No. 1817 Madison Ave. St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1878.
(Month) (Day) (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Ezekiel Rudaitzky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sheine

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore St

15- NOV 21 1920

Filed....., 191.....

ROBERT B KRAUTER
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1920, to Nov 21 1920, that I saw her alive on Nov 21 1920, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Dilatation of the heart

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Benjamin Pushkin M. D.

Nov 21, 1920. (Address) 1804 Eutaw place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Sterling Run

DATE OF BURIAL. 11/22, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

6 48232 HEALTH DEPARTMENT--CITY OF BALTIMORE 6 48232

CERTIFICATE OF DEATH

64

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3422 Auchentorly Terrace. St. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Benjamin Kluff.

(Residence in Baltimore: No. 3422 Auchentorly Terrace St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	widower,

6 DATE OF BIRTH Unknown. (Month), 1838 (Day) (Year)

7 AGE 82 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired merchant 045
(b) General nature of industry, business, or establishment in which employed (or employer): merchant

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Kluff.

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Zelda —

13 BIRTHPLACE OF MOTHER (State or country): Russia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1411 E. Balt St.

15 Filed NOV 21 1920, 191 — ROBERT B KRAUTER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November (Month) 20 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1920, 191, to Nov. 20 1920

that I saw him alive on Nov. 20th, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds

Contributory (SECONDARY) High Blood Pressure,

(Duration) many yrs. mos. ds.

(Signed) David I. Macht M. D.

Nov. 21, 1920 (Address) 3420 Auchentorly Ter.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Lebanon Rosedale — DATE OF BURIAL: 11-24-1920

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balt St

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048233

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048233

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 509 S Madeira St. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Goldbeck.

(a) RESIDENCE. No. 509 S. Madeira ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Goldbeck

6 DATE OF BIRTH (month, day, and year) Feb 8th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Goldbeck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elij. Dabhorn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Goldbeck.

(Address) 509 S. Madeira St.

15 Filed NOV 21 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to Nov 19, 1920, that I last saw him alive on Nov 17, 1920, and that death occurred, on the date stated above, at 10.50 a m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B P Herzog M. D.

1920 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 23rd 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PLEASE USE PEN AND INK—WRITING UNDERLINE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48234

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2620 E. Fairmount Ave St.) 6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Stenger.

(a) RESIDENCE. No. 2620 E. Fairmount Ave 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John E. Stenger

6 DATE OF BIRTH (month, day, and year) June 6 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Jos. Doberneck.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Anthoyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: James B. Stenger
(Address) 3410 Phila ave.

15 Filed NOV 21 1920 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17 1920 to Nov 19 1920 that I last saw her alive on Nov 18 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Senile Nephritis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Genuine Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov. 19

Was there an autopsy? No

What test confirmed diagnosis? Objective symp.

(Signed) G. E. Klenk, M. D.

, 19 (Address) 120 E. Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 23rd 1920
20 UNDERTAKER: Lilly & Zeiler	ADDRESS: 400 N. Wolfe St

Burial Permit Clerk

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

USE BLACK INK

D48235 HEALTH DEPARTMENT—CITY OF BALTIMORE D48235

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 110 Winter St. ST.: 23 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irma Butz. 40 ----------

(Residence in Baltimore: No. 110 Winter St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Married.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. ---- mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 037
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Relay, Md.

PARENTS.

10-NAME OF FATHER, John Wesley. (C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Catherine------(C)

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Cross (C) niece.....

(Address) 584 Forsyth Alley.

15-
Filed NOV 21 1920 191.....
ROBERT B KRAUTER
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 18th. 1920. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....
Rupture of an Aortic Aneurism.....
Syphilis.....
..... (Duration).....yrs.....mos.....ds.
CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Einhaus M. D.
(Coroner.)
Nov. 19, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Elkridge Md. DATE OF BURIAL, Nov. 21, 1920

20-UNDERTAKER R. L. Forham ADDRESS 1219 W. Lee St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. 32 54

Spec.—6-9-19—H. P. Co.—1000 Rks.

1048236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1048236

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2519 Madison Ave ST., 13 WARD)

2-FULL NAME Isaac Shapiro

(a) RESIDENCE. No. 2519 Madison Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs — mos. — ds. How long in U. S., if of foreign birth? 27 yrs — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of M Zinberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Realestate

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Shapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie Benerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Annie Shapiro
(Address) 2519 Madison Ave

15 NOV 21 1920 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11th 1920, to Nov. 20 1920, that I last saw him alive on Nov. 20 1920, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

Nov.

(duration) — yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Pelletreau, M. D.

11/20 1920 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Nov. 22 1920
20 UNDERTAKER J. Levinson	ADDRESS 117 E Balto st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48237

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Foster Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. Morris

(a) RESIDENCE. No. 3603 Foster Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. 9 mos. 8 ds. (If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Lillian M. Morris

6 DATE OF BIRTH (month, day, and year): Feb 10/88

7 AGE — Years: 32 — Months: 9 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milk Wagon driver

(b) General nature of industry, business, or establishment in which employed (or employer): driver

(c) Name of employer: Western Md. Dairy

9 BIRTHPLACE (city or town) (State or country): Phila Pa.

PARENTS

10 NAME OF FATHER: Fred. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Lillian M. Morris

(Address): 3603 Foster ave

15 Filed NOV 21 1920 ROBERT B. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/17/20, 19.., to 11/18/20, 19.., that I last saw him alive on 11/17/20, 19.., and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Rheumatism (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) J. W. Freeman, M. D.

11/20/20 19.. (Address) 919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Nov 22 1920

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948238 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948238

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Dziecichocz (Smith)

(a) RESIDENCE. NO. 2121 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Casimir Dziecichocz (Smith)

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Helen Rybitske

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed NOV 21 1920 ROBERT R KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1920, to Nov 20th, 1920, that I last saw h.r alive on Nov 20th, 1920, and that death occurred, on the date stated above, at 3 15 a m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X ray + Skin test

(Signed) W C Davison, M. D.

, 19 (Address) J H H Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov 20 1920
20 UNDERTAKER	ADDRESS
Stephen J Kalkowski	1003 S Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048239 HEALTH DEPARTMENT—CITY OF BALTIMORE 048239

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St.; 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Fischer

(a) RESIDENCE. No. 518 S. First St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresia Fischer

6 DATE OF BIRTH (month, day, and year): April 5-1861

7 AGE: Years 59; Months 7; Days 15; If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer): at Balto Co. W. W.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md.

PARENTS

10 NAME OF FATHER: Christian Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Theresia Fischer

(Address) 518 S. First St.

NOV 21 1920

ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Nov 20, 1920, that I last saw h.[illegible] alive on Nov. 20, 1920, and that death occurred, on the date stated above, at 12.45 p m.

The CAUSE OF DEATH* was as follows:

Gangrene of left leg

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 20 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture & microscopy.

(Signed) Thomas F. Healy, M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Nov. 23 1920

20 UNDERTAKER: Tilly & Zeile.

ADDRESS: 403 S. [illegible]

Seitz Seitz

1048240 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048240

CERTIFICATE OF DEATH.

1048240

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3811 Garden Ave ST.: 26 WARD) 168

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Seitz

(Residence in Baltimore: No. 3811 Garden Ave St.: yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7-AGE. 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Zeberlein

(Address) 625 S. Bond St

15-

Filed NOV 21 1920 ROBERT R KRAUTER

Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation find that said deceased came to death
(Inquest, autopsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Asphyxia by Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Fox Eberly M. D.
(Coroner.)

Nov 21, 1920. (Address) 1610 N Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	Nov 22, 1920
20-UNDERTAKER	ADDRESS
Felty & Feile	4038 Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Chas. J. Bolgiano

D48241 HEALTH DEPARTMENT—CITY OF BALTIMORE D48241

CERTIFICATE OF DEATH. 168

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 8 Elmhurst Road ST.; 22nd WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas J. Bolgiano

(Residence in Baltimore: No. 8 Elmhurst Road St.; 43 yrs., 5 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	W	M

6-DATE OF BIRTH, May 29, 1877
(Month) (Day) (Year)

7-AGE, 43 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... C J Bolgiano (Sash)
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph A Bolgiano

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mary Wolton

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emily R Bolgiano

(Address) 8 Elmhurst Road

15- NOV 21 1920 Filed ....., 191.... ROBERT B KRAUTER Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Asphyxiation
(b) Carbon Monoxide
Gas - accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.
(Coroner.)

Nov 20 1920 (Address) 3632 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Nov 23 1920
20-UNDERTAKER George Smith & Son	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48242 HEALTH DEPARTMENT—CITY OF BALTIMORE D48242

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 E. 22nd St. ; ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Flynn

(a) RESIDENCE. NO. 719 E. 22nd St., ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work,

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Kathrine Flynn
(Address) 719 E. 22nd St.

15 NOV 21 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/20 19

17 I HEREBY CERTIFY, That I attended deceased from 11/12/19 19 to 11/19/20 19

that I last saw h[illegible] alive on 11/19/20 19

and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Uremic Seizure 0 7 2 V

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? none

(Signed) Wm Sudders, M. D.

11/20/20 (Address) 221 E 25th.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's. (Govans.)	Nov. 22 1920
20 UNDERTAKER	ADDRESS
Liston P. Funeral Co.	2620 St. Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. In physician's estimation woman considerably older.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048243

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048243

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Pearl Smith

(a) RESIDENCE. NO..... Athens Ala ST., ... WARD. Route 11

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Ala~~ Tenn

PARENTS

10 NAME OF FATHER L H Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala

12 MAIDEN NAME OF MOTHER Ellis Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

14 Informant T. P. Smith (Address) Athens Ala

15 Filed NOV 21 1920 ROBERT E LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from 11—17, 1920, to 11/20, 1920

that I last saw her alive on 11/20, 1920

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

? (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 11/17/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 * (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Athens Ala.	Nov. 21 1920
20 UNDERTAKER	ADDRESS
William G. Schaffer	1816 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48244 HEALTH DEPARTMENT--CITY OF BALTIMORE D48244

CERTIFICATE OF DEATH

Registered No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Calvert & 31st St. Calvert & Eplo St. 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Wilfflein Holladay

(Residence in Baltimore: No. Calvert Court. Apt. B.3. St.: 37 yrs. 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: July (Month) 5 (Day), 1883 (Year)

7-AGE: 37 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Electrician 066
(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Geo. Tilghman Holladay

11-BIRTHPLACE OF FATHER (State or country): Chestertown, Md

12-MAIDEN NAME OF MOTHER: Celenia Brice Chamberlain

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. T. Holladay

(Address) 3905 Bellone.

NOV 21 1920 Filed ....., 191

ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30, 1920, to Nov 20, 1920, that I saw h~~im~~alive on Nov 20, 1920, and that death occurred, on the date stated above, at 12.50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
First attack Oct. 30-1920 slight

(Duration) ..... yrs. ..... mos. 21 ds

Contributory (SECONDARY) 2nd attack Nov-19-with stroke resulting in 3 hrs 50 min

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), John S. Rishel M. D.

Nov 20, 1920 (Address) 730 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: Nov. 22, 1920

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

1048245 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048248

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 314 W. 28 St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Gilman

(Residence in Baltimore: No. 314 W. 28 St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: November, 18, 1871
(Month) (Day) (Year)

7-AGE: 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Ind.

PARENTS.

10-NAME OF FATHER: William Gilman

11-BIRTHPLACE OF FATHER (State or Country): Ind.

12-MAIDEN NAME OF MOTHER: Mary Collins

13-BIRTHPLACE OF MOTHER (State or Country): Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Collins

(Address) 314 W 28 St

15- Filed NOV 21 1920, 191.... ROBERT E KRAUTER Registrar.

Burial Permit ....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November, 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. Thomas M. D.
(Coroner.)

Nov 19 1920 (Address) 362 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence New Jordan Conn

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Nov. 20, 1920

20-UNDERTAKER Samuel A Hensley ADDRESS 578 Biddle St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48246 HEALTH DEPARTMENT—CITY OF BALTIMORE D48246

CERTIFICATE OF DEATH. X 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 780 W. Mulberry St ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Richmond Va.

2-FULL NAME Marion Dickerson

(a) RESIDENCE. No. 780 W. Mulberry St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Dickerson

6 DATE OF BIRTH (month, day, and year) Unknown 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER George Drange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Laura Littlejohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Robt Dickerson (Address) 780 W Mulberry St

15 Filed NOV 21 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1920, to Nov. 20, 1920, that I last saw her alive on Nov. 20 —, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lung

Tuberculosis of Lung;

(duration) yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 7 mos. 5 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leigh Kennard M. D.

11-24. 1920 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL Nov 22, 1920

20 UNDERTAKER Samuel Hinsley

ADDRESS 178 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1048247 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048247

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2734 N. Mosher ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Flanagan

(a) RESIDENCE. No. 2334 N. Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Patrick F. Flanagan

6 DATE OF BIRTH (month, day, and year): Dec 23 1858

7 AGE: Years 61 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Banahan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Banahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: P. F. Flanagan

(Address) 2334 N. Mosher St

15 Filed NOV 21 1920 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/19 19 19, to 11/19 19 20, that I last saw h alive on Nov. 19 19 20, and that death occurred, on the date stated above, at 7 30P m.

The CAUSE OF DEATH* was as follows:

Exhaustion due to Carcinoma Body Uterus.

Duration of Tumor 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tumor + Melodrama

(Signed) Stanislaus McCleary, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	11/22 1920
20 UNDERTAKER	ADDRESS 3000 E. Baltimore St
J. F. Moran	

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

1048248

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048248

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 640 S. Potomac ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dtugh Eyton Gross

(a) RESIDENCE. No. 640 S. Potomac ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate C. Gross

6 DATE OF BIRTH (month, day, and year) Feb. 22-1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Georg Gross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Harvey M. Gross. (Address) 640 S. Potomac St.

NOV 22 1920 ROBERT B KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16th, 1920, to Nov. 19th, 1920, that I last saw him alive on Nov. 18th, 1920, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Singwald, M. D.

11/22 1920 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Nov. 22 1920
20 UNDERTAKER	**ADDRESS**
Lilly & Zeiler	1103 E. Monument.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048249 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048249

CERTIFICATE OF DEATH. 131

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hos. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Belle Wilkinson

(a) RESIDENCE. No. 3030 Walbrook St., Ward.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. J. Wilkinson

6 DATE OF BIRTH (month, day, and year) Oct. 29 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant W. J. Wilkinson (Address) 3030 Walbrook Ave

15 NOV 22 1920 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Nov 20, 1920, that I last saw her alive on Nov 20, 1920, and that death occurred, on the date stated above, at 7.35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cyst of Eyelid

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Md. Gen'l Hosp.

Did an operation precede death? Yes Date of 11/18/20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. F. Hoffy Pumphrey, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clayton N. J.	Nov 22 1920
20 UNDERTAKER	ADDRESS
Wm. F. Tickner & Sons	N. & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D48250 HEALTH DEPARTMENT—CITY OF BALTIMORE D48250

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Guilford Ave ST.; 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles William Jones

(Residence in Baltimore: No. 2332 Guilford Ave St.; 6 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PROFESSIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 28 (Day), 1856 (Year)

7-AGE, 64 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tool maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Utica N.Y.

PARENTS.

10-NAME OF FATHER, Charles Jones Jr.

11-BIRTHPLACE OF FATHER (State or Country), Wales

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida May Christ

(Address) 2332 Guilford Ave

15- NOV 22 1920 ROBERT B KRAUTER Funeral Director

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Nov 21 1920, that I saw him alive on Nov 21 1920, and that death occurred, on the date stated above, at 5.10 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas A Schaefer M. D.

Nov 21, 1920. (Address) 57 S. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Nov 23, 1920

20-UNDERTAKER W. E. Lake ADDRESS 502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048251

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048251

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 McHenry ST.; 23 WARD)

2-FULL NAME Priscilla B Kirby

(a) RESIDENCE. NO. 2104 S. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Edward Geay Kirby

6 DATE OF BIRTH (month, day, and year) Jan 14 1841

7 AGE — Years: 79 — Months: 9 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Tuckey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Mirah Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant Geo B Kirby
(Address) 2104 S Charles St

15 NOV 22 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Nov 19th 1920, that I last saw h[illegible] alive on Nov 19th 1920, and that death occurred, on the date stated above, at 1139 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) By Physician, M. D.

11/20/20 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 23 1920

20 UNDERTAKER: W E Lash — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

048252

HEALTH DEPARTMENT—CITY OF BALTIMORE

048252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Baker St. 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Washington

(Residence in Baltimore: No. 620 Baker St.; 1 yrs., 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar ....., 1880
(Month) (Day) (Year)

7-AGE, 40 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Palmer

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Washington

(Address) 620 Baker St

15- NOV 22 1920 Filed....., 191.... ROBERT B BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22nd 1920, to Nov 19th 1920, that I saw her alive on Nov 19th 1920, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Harry T Bryan M. D.

Nov 20, 1920 (Address) 1501 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 22, 191...

20-UNDERTAKER Hammond Dyche & Lynch Co

ADDRESS

Spec—6-19—H. P. Co.—1000 Bks.

D48253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48253

CERTIFICATE OF DEATH.

X 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rudd

(a) RESIDENCE. NO. Lutherville, Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Rudd

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Pauline Focke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. C.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed . 19 Registrar

NOV 22 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21st 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1920, to Nov 21st, 1920, that I last saw h.e alive on Nov 21st, 1920, and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Bacteriology

(Signed) Wm. Dowson, M. D.

. 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph's Texas	Nov 23 1920
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48254

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 W. Mulberry St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Morrow

(a) RESIDENCE. No. 1803 W. Mulberry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Morrow

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1832

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mr. Ritter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Robert J. Morrow
(Address) 1803 Thames Ave.

Filed NOV 22 1920 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 1-20, 19 20, to Nov-18 19 20, that I last saw her alive on Nov 18, 19 20, and that death occurred, on the date stated above, at 8.25 a.m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. [illegible]

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cot, M. D.

11.19 1920 (Address) 543 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov. 22, 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto. Street

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 214 S. Smallwood St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Marie Bauer

(a) RESIDENCE. NO. 214 S. Smallwood St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Bauer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Rupp

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Charles Bauer
(Address) 214 S. Smallwood St.

15 Received NOV 22 1920 ROBERT P. LEA, M.D. Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1920, to Nov 19, 1920
that I last saw her alive on Nov 19, 1920
and that death occurred, on the date stated above, at 5 50 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arthemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? (Date of (

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Theodore Lederman, M. D.

Nov 20, 1920 (Address) 324 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Nov 23' 20 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 48256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48256

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 6424

CITY OF BALTIMORE: (No. 748 Eutaw St ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Bailey

(a) RESIDENCE. No. 746 W Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Auto works
(c) Name of employer Mrs Mary Griffin Mt Washington Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John D Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Bloom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Paul B. Bailey 300 Eden Ave Belair

Filed NOV 22 1920 Registrar

ROBERT B. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 , 1920 , to Nov 20 , 1920 , that I last saw him alive on Nov 20 , 1920 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of lungs 4

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? none Date of

Was there an autopsy?

What test confirmed diagnosis? T.B Bacilli in sputum

(Signed) S. O. Ridgley , M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rosemary Md	Nov 23 1920

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48257

137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St. 21 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Carson

(a) RESIDENCE. No. 1159 Ward St., 21st Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of ~~foreign birth~~? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Carson

6 DATE OF BIRTH (month, day, and year) Unknown 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Denny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frank S. Carson

(Address) 1159 Ward St

15 Filed NOV 22 1920 ROBERT J. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 21, 1920, that I last saw her alive on Nov 20, 1920, and that death occurred, on the date stated above, at 10.20a m.

The CAUSE OF DEATH* was as follows:

Ovarian cyst & fibroid uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 18

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Crumpton, M. D.

11/22/1920 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Nov 23" 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1037 Bolton St.

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

048258 ✓ 048258

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minerva Adams.

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed NOV 22 1920 19 [illegible] Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 27, 1920, to November 19 1920, that I last saw him alive on November 18, 1920, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myoma of uterus
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) [illegible], M. D.

11/19/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	November 22 1920
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48259

HEALTH DEPARTMENT—CITY OF BALTIMORE

55-02 D48259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 5 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Taylor

(a) RESIDENCE. No. 112 Colvin St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emanuel Taylor

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed NOV 22 1920 19 ROBERT B KRAUTER Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 15 1920. to November 18 1920. that I last saw h.. alive on November 18, 1920. and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lethargic encephalitis.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V B Emerson. M. D.

11/19/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Nov 22 19 20
20 UNDERTAKER: John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P Co.—1000 Bks.

D48260 HEALTH DEPARTMENT—CITY OF BALTIMORE D48260

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 E Lombard ST.: W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander C Messick

(a) RESIDENCE. No. 2016 E. Lombard ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Messick

6 DATE OF BIRTH (month, day, and year) Dec 10, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Messick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary A. Messick

(Address) 2016 E Lombard St

15 NOV 22 1920 ROBERT B. ELLIOTT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1920

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Nov 18, 1920, that I last saw h... alive on Nov 18, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Cook, M. D.

. 19 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 20 1920
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son	811 N Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48261 D 48261

CERTIFICATE OF DEATH.

91-061

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Millington Lane ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon aloysius Shaner

Residence in Baltimore: No. 426 Millington Lane St.: 1 yrs., mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, October 23, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 28 mos. ds.
If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto., Md

PARENTS.

10-NAME OF FATHER, William F. Shaner

11-BIRTHPLACE OF FATHER (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER Edith M. Faherty

13-BIRTHPLACE OF MOTHER (State or Country), Balto., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Shaner,

(Address) 426 Millington Lane

15- ROBERT F. LEAUTER
NOV 22 1920 191... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2d 1920, to Nov 20th 1920, that I saw h[illegible] alive on Nov 19th 1920, and that death occurred, on the date stated above, at 8:25 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Accidental Meningitis

(Duration) ....yrs. mos. 1 ds.

(Signed) J. B. Lemmerhirt M. D.

11/20, 1920 (Address) 1800 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys Cemetery (Hamden) DATE OF BURIAL, Nov 22, 1920

20-UNDERTAKER Harry H. Wittke ADDRESS 1031 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. F. Co.—1000 Blks.

D48262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48262

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. ..... ST.: 25 WARD)

REGISTERED NO. 82

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mac Mayo.

(a) RESIDENCE. No. Second near 3rd St. Fairfield WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver (Ice)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do. Unknown

14 Informant (Address) Bayview Hospital Balto, Md.

15 Filed NOV 22 1920 BUREAU OF VITAL STATISTICS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Nov. 20, 1920, that I last saw him alive on Nov. 19, 1920, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) H. Fredericks, M. D.

11/21/1920 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	Nov 23 1920
20 UNDERTAKER	ADDRESS
John F. Deery	715 Light St

N. B.—WRITE PLAINLY WITH INK AND IN ENGLISH. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Coulbourn

D48263 HEALTH DEPARTMENT—CITY OF BALTIMORE D48263

CERTIFICATE OF DEATH.

REGISTERED No. C 2519

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 214 N. 1st. St. Brooklyn. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ludie E. Coulbourn.

(Residence in Baltimore: No. 214 N. 1st. St. Brooklyn St.; 27 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Married

6-DATE OF BIRTH, November 4th. 1876, 1 (Month) (Day) (Year)

7-AGE, 44 yrs. 0 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Howard Co. Md.

PARENTS.

10-NAME OF FATHER, John A. Iglehart

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md.

12-MAIDEN NAME OF MOTHER, Eugene Knight.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Seward L. Coulbourn. (husband)

(Address) 214 N. 1st. St. Brooklyn.

15- Filed NOV 22 1920, 191 ROBERT P. LEE Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. C. Reinhardt M. D. (Coroner.)

Nov. 19, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
CEDAR HILL	NOV 22 1920

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

D48264 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Elks Club W. Fayette ST. 17 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Graham Walker

(Residence in Baltimore: No. Fremont & Lafayette ave city St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dont Know (Month) (Day), 1867 (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer), 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas S Walker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Addie Earhatt Walker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Walker

(Address) 733 W Lafayette Ave

NOV 22 1920 Filed, 191 ROBERT B KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Coroner, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know If any

(Duration) yrs. mos. ds.

(Signed) W K Gorsuch M. D. (Coroner.)

11.22. 1920 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Nov 22, 1920

20-UNDERTAKER Walter Foster Jr & Son — ADDRESS 1827 W Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48265 HEALTH DEPARTMENT—CITY OF BALTIMORE D48265

CERTIFICATE OF DEATH.

155

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 603 Oakland Ave ST.; 1 WARD)
REGISTERED No. C .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Foster
(Residence in Baltimore: No. 603 Oakland Ave
Oakland Ave
1 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1888 (Day) (Year)

7-AGE, 32 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Wood Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.A.

9-BIRTHPLACE, (State or Country), Kansas

PARENTS.
10-NAME OF FATHER, Frank Foster
11-BIRTHPLACE OF FATHER (State or Country), Indiana
12-MAIDEN NAME OF MOTHER Einstein
13-BIRTHPLACE OF MOTHER (State or Country), Indiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Kansas Foster
(Address) 603 Oakland Ave

15- NOV 22 1920 DOROTHY I KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide by Hanging
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... (Coroner.) ..... M. D.
....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn
DATE OF BURIAL, Nov 23rd, 1920
20-UNDERTAKER Martin Fahey & Sons
ADDRESS 827 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

948266 HEALTH DEPARTMENT—CITY OF BALTIMORE 948266

CERTIFICATE OF DEATH.

19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 N Wolf ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Eugene Russell Linton

(a) RESIDENCE. No. 1838 N Wolf ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13.	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward W Linton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Birdie B McCurdy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Edward W Linton
(Address) 1838 N. Wolf st

15 Filed NOV 22 1920 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 19 20, to Nov 18, 19 20, that I last saw h alive on Nov 18, 19 20, and that death occurred, on the date stated above, at 10 45 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) J. L. Hearn, M. D

Nov 20 19 20 (Address) 1301 N Bat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 22 1920
20 UNDERTAKER Robt J Turner Jnr	ADDRESS 1442 Broadway

WHITE PAPER, WITH UNFADING INK—THIS ITEM of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 48267 ✓ 1700 D 48267

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 3644 Beach Ave 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice A High

(a) RESIDENCE. No 3644 Beach Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Alford A. High

6 DATE OF BIRTH (month, day, and year) Feb 7. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Baughman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Cherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry High

(Address) 3644 Beach Ave

15 Filed ..... 19 ROBERT B. KRAUTH Registrar

NOV 22 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920, to Nov. 20, 1920, that I last saw her alive on Nov. 19, 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis

(b) Uraemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Surely Symptoms & urinalysis

(Signed) Chas. F. Congalton, M. D.

11-20, 1920 (Address) 3701 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 23 1920
20 UNDERTAKER	ADDRESS
Wm. E. Chenoweth Son	Cheltenham 367

N. B.—WRITE PLAINLY, WITH CAP LETTERS. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48268

CERTIFICATE OF DEATH.

1132

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3105 Huntington Ave (WARD) 12

2-FULL NAME Margard A Stroble

(a) RESIDENCE. No. 3105 Huntington Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Stroble

6 DATE OF BIRTH (month, day, and year): March 14 1855

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Frank E Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie E Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Martha M Redman

(Address) 3105 Huntington Ave

15 Filed NOV 22 1920

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Nov 20 1920, that I last saw her alive on Nov 20 1920, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Kidney (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C A Richardson, M. D.

Nov 20 1920 (Address) 1124 N 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery | DATE OF BURIAL: Nov 23 1920

20 UNDERTAKER: Ebenezer Sons | ADDRESS: Chestnut St

N. B.—WHITE PAPER. PRINT. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of ... ck of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48269 HEALTH DEPARTMENT—CITY OF BALTIMORE D48269

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Stapleton Ave & Greenhill Ave ST.; Gardenville WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo Keyser

(Residence in Baltimore: No. Stapleton Ave & Greenhill Aves St.; 70 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH, Oct (Month) 4 (Day), 1850 (Year)

7-AGE 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Joseph Keyser

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Martha Hawk

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Reinhart

(Address) Stapleton & Greenhill

15- Nov 22 1920, 191.....

Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Wed (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 18 1920, to Wed 20 1920, that I saw h.. alive on Wed 20 1920, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Atherosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm D Cosse M. D.

Nov 22, 1920 (Address) Gardenville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Nov. 24th, 1920
20-UNDERTAKER	ADDRESS
Frank Lassahn & Sons	Fullerton Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048270 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048270

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere ave ST.: Druid Hill Rd WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fitzbergen

(a) RESIDENCE. No. Belvedere ave ST., WARD. 25 yrs
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 059

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer & Stove business

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Fitzbergen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine M Shikuer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mrs Emma Kannsbrer
(Address) 1900 W North ave

15 Filed NOV 22 1920 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov 19, 1920, that I last saw h. alive on Nov 18, 1920, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Leukemia

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) Chas J Mills, M. D.

Nov 20 1920 (Address) 1 E Pleasant & Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 22 1920
20 UNDERTAKER	ADDRESS
W M Rouleau	2258 W Baltimore

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48271

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2834 Harlem ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Davis

(a) RESIDENCE. NO. 2837 Harlem ave. 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Davis

6 DATE OF BIRTH (month, day, and year) April 29/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Earnest Fiesthe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William W Davis

(Address) 2837 Harlem ave.

15 Filed NOV 22 1920 19 ROBERT E KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1920

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to Nov 16, 1920, that I last saw h[illegible] alive on Nov 16, 1920, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Interstitial Nephritis.

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas V. Sheets, M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 23 1920
20 UNDERTAKER	ADDRESS
F. A. Tranter & Son	703 Hanover

MEDICAL CERTIFICATE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48272

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Hampton

(a) RESIDENCE. NO. 2200 Fairmount Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED 186

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Hampton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Fowler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

Filed NOV 22 1920, 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1920, to Nov. 20, 1920, that I last saw him alive on Nov. 20, 1920, and that death occurred, on the date stated above, at 4.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? T.B. in sputum, X-ray

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

11-20-20 (Address) Municipal Tbc Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 22 1920
20 UNDERTAKER Robt Johnson Inc	ADDRESS 1442 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER 1 DAY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48273

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Homewood, ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rasolins Rendel (Mrs)

(a) RESIDENCE. No. Fifth Haven Road ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): [illegible] 1857

7 AGE: Years 63 Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 640

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): John Adams Work Farm

15 Filed NOV 22 1920, Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1920, to Nov 22, 1920, that I last saw h[illegible] alive on Nov 22, 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Raymond Glaser, M. D.

(Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Nov 24 1920

20 UNDERTAKER: John Oslobiansas — ADDRESS: 425 S. [illegible]

NOV 22 1920

Burial Permit

mation should be carefully supplied. AGE should be stated EXACTLY. NAMES should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

LAUBER

D.48274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48274

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 Riverside Ave ST.; 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anna Lauber

(Residence in Baltimore: No. 1243 Riverside Ave St.; 36 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	W	Married

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1884 (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 4 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Leonard P. Hascher

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Hagerdorn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Schraen

(Address) 1243 Riverside ave

15- NOV 22 1920 Robert P. Harrison,
Registered ....., 191..... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31 27 (Month) (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1926, to Nov 21 1926, that I saw h er alive on Nov 21 1926, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) August Klein M. D.

Nov 21, 1926 (Address) 4062 5 Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem DATE OF BURIAL, Nov. 24, 1926

20-UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Luzerne ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48275

CERTIFICATE OF DEATH. 154

1-PLACE OF DEATH 1128 N. Calhoun St.

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Wilhelm

(Residence in Baltimore: No. 1 St.; ..... yrs., ... mos. 1½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. 17, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 17 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland (Balto.)

PARENTS.

10-NAME OF FATHER, Clarence Wilhelm

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Maryland

12-MAIDEN NAME OF MOTHER Margaret Young

13-BIRTHPLACE OF MOTHER (State or Country), Maryland (Balto)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- NOV 22 1920 JOHNS HOPKINS HOSPITAL

Robert P. Harrison, Registrar.

Burial Permit Clerk.

17658

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17 1920, to Nov. 18 1920, that I saw her alive on Nov. 17 1920, and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arthur J Bortner M. D.

Nov 19 1920 (Address) White Hall Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health,

ADDRESS NOV 2 1920

Dep. Wm. E. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48276

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Williams

(a) RESIDENCE. No. 1030 Maldies ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 1 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ood

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER Max Williams

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Appel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Robert P. Harrison,

NOV 22 1920

15 Filed ..... 19 Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov 21, 1920, that I last saw h.er alive on Nov 20, 1920, and that death occurred, on the date stated above, at 1.25 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. M. H. Clift, M. D.

Nov 21, 1920 (Address) 27 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	NOV 22 1920
20 UNDERTAKER Commissioner Health.	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.48277 HEALTH DEPARTMENT—CITY OF BALTIMORE D48277

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 N. Castle ST.: 8, WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie A. Hopps

(a) RESIDENCE. No. 1822 N. Castle ST., 8, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of R. F. Hopps

6 DATE OF BIRTH (month, day, and year) Aug. 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cincinnatti (State or country) Ohio

PARENTS

10 NAME OF FATHER David Jennings

11 BIRTHPLACE OF FATHER (city or town) Cincinnati (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Edwin B. Fenby (Address) 1223 N. Caroline st.

15 Filed NOV 22 1920 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1920, to Nov. 21, 1920, that I last saw her alive on November 20, 1920, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

Probably (duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Gall stones

Uncertain (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Edwin B. Fenby, M. D.

11/22, 1920 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 24 1920
20 UNDERTAKER	ADDRESS
J. Henry Lutz	1007 N. Bond st

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Cofresso

D.48278 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital 42 REGISTERED NO. C.....

CITY OF BALTIMORE; (No. Monument Mc Rutland ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Diona Cofresso

(Residence in Baltimore: No. 937 N. Duncan St.; 47 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Angelo Mazzone

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carmen Cofresso

(Address) 737 N. Duncan St.

15- NOV 22 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 21 1920, that I saw h[er] alive on Nov 21 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of Body of Uterus

..... (Duration).....yrs. 10 mos.....ds.

CONTRIBUTORY (Secondary) Anemia (Duration).....yrs.....mos. 8 ds.

(Signed) [illegible] M. D.

11-21-20, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov 23, 1920

20-UNDERTAKER Funk & Crack Son — ADDRESS 1906 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48279 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48279

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 942 Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew Hlavacek

Residence in Baltimore: No. 942 N. Castle St.; 85 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Not Known (Month) (Day) 1 (Year)

7-AGE, 56 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Hlavacek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Emma Rolenc

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Hlavacek

(Address) 942 N Castle St

15- NOV 22 1920

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 22 1920, that I saw [illegible] alive on Nov 22 1920, and that death occurred, on the date stated above, at 2130 m.

The CAUSE OF DEATH* was as follows:

Cause [illegible] Nephritis and Uraemia

Gastritis and Enteritis

(Duration) 15 yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Gastritis Chronic Nephritis

(Duration).....yrs.....mos.....ds.

(Signed) Edward J. Sellers M. D.

Nov 22, 1920 (Address) 1025 N Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE; (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill	Nov 24, 1920
20-UNDERTAKER Frank Crack Son	ADDRESS 1966 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48280 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48280

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1609 Shakespheare ST.; W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jarosinski

(a) RESIDENCE NO. 1609 Shakespheare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agatha Jarosinski

6 DATE OF BIRTH (month, day, and year) Jan 15 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher D13

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer him self

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wicenty Jarosinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Felicia Krzemisk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Agatha Jarosinski 1609 Shakespheare

15 Filed NOV 22 1920 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 1920, to Nov. 21st, 1920, that I last saw him alive on Nov. 21st, 1920, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Dr. W. Turnbull, M. D.

, 19 (Address) 2323 Callard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosaff Row	24 1920
20 UNDERTAKER	ADDRESS
John H. Weber	1803 Bank St

NOTE—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48281 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48281

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2537 Filut St ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luis Fiabierkiewicz

(a) RESIDENCE. NO. 2537 Filut St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bronislawa Fabierkiewicz

6 DATE OF BIRTH (month, day, and year) Dec 2 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER George Fabierkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Lewandowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Bronislawa Fabierkiewicz (Address) 2537 Filut

15 Filed NOV 22 1920 Robert P. Harrison, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 to Nov 20 1920, that I last saw her alive on Nov 20 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Shock Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) W. A. Miller, M. D.

, 19 (Address) 2458 Ballt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 23 1920
20 UNDERTAKER	ADDRESS
John McEvoy	1803 Bank

A. B.—WRITE PLAINLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48282

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 E chase ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Byrnes

(a) RESIDENCE. NO. 2025 E Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Matthew Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Mical

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Barbara Mical (Address) 2025 E Chase St

15 Filed NOV 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1920

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1920, to November 21, 1920, that I last saw h.. alive on November 21, 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Broken compensation)

I (duration) for many childhood yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

, 19 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 25 1920

20 UNDERTAKER Jas C Miller ADDRESS 2334 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48283 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N Glover St.; 7 Ward) REGISTERED No. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cox

(a) RESIDENCE. No. 529 N Glover St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Cox 1860

6 DATE OF BIRTH (month, day, and year) April 13 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magnud Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Shaffner 529 N. Glover St

15 Filed NOV 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Nov 20, 1920, that I last saw h[illegible] alive on November 20, 1920, and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Fatty Degeneration)

(duration) intervan yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Lyd, M. D.

19 (Address) 2065 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Nov 24 1920
20 UNDERTAKER	ADDRESS
Jas E. Miller	2334 Jefferson St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48284 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48284

CERTIFICATE OF DEATH. X 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2030 Huntingdon Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Wilson Gessford

(a) RESIDENCE. No. 2030 Huntingdon Ave ST., WARD. ? Kansas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Gessford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Joseph Gessford
(Address) 2030 Huntingdon Ave

15 Filed NOV 22 1920, 19 Robert F. HARRISON, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1920, to Nov 20th, 1920, that I last saw h[illegible] alive on Nov 19th, 1920, and that death occurred, on the date stated above, at 11-35 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. T. Fair, M. D.

Nov 22, 1920 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery, Maryland Md — DATE OF BURIAL: Nov 23, 1920

20 UNDERTAKER: C. LeRoy Stifflew, 125 E North Ave. — ADDRESS

I. B.—WRITE LEGIBLY. Use only Black Ink. All items and the AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48285

D48285

CERTIFICATE OF DEATH.

REGISTERED NO. 1920 D48285

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Greenway Apartments ST.: 12 WARD)

2-FULL NAME Sadie Kreeger Miller

(a) RESIDENCE. No. Greenway Apartments ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R Miller

6 DATE OF BIRTH (month, day, and year) Oct 7 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Samuel Kneller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Doll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas R. Miller
(Address) Greenway apartment

15 NOV 23 1920 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1918, to Nov 20, 1920, that I last saw her alive on Nov 20, 1920, and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

done

"Uraemia"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism Brain Brain (Coronary)

(duration) 2 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph T. Stevens, M. D.

, 19 (Address) Walker Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druids Ridge Cem	Nov 23 1920
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

A. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 48286

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 1 WARD)

2-FULL NAME Mrs. Frances Guthrie

(a) RESIDENCE. NO. 3824 Potomac St. ST., ~~Ward~~. Dallas, Texas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	MARRIED

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of E. B. Guthrie

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) U.S.A. (State or country)

PARENTS

10 NAME OF FATHER Roger M. Williams

11 BIRTHPLACE OF FATHER (city or town) Alabama (State or country)

12 MAIDEN NAME OF MOTHER Sarah R Phillips

13 BIRTHPLACE OF MOTHER (city or town) Alabama (State or country)

14 Informant Eugene B Guthrie (Address) Dallas Texas

15 Filed NOV 23 1920, 19.... ROBERT B. LAZARUS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1920, to Nov. 22, 1920, that I last saw her alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (glioma)

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 21, 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry M. Thomas Jr. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallas, Texas

DATE OF BURIAL Nov 23 1920

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48287

CERTIFICATE OF DEATH.

5 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 507 Somerset St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Stanly

(a) RESIDENCE. NO. 507 Somerset ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebe Stanly

6 DATE OF BIRTH (month, day, and year) July 26 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fertilizer worker

(b) General nature of Industry, business, or establishment in which employed (or employer) O'Hara

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Stanly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Rebe Stanly

(Address) 507 Somerset

15 Filed NOV 23 1920 19.... ROBERT B. ARAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to Nov 20, 1920, that I last saw h... alive on Nov 15, 1920, and that death occurred, on the date stated above, at 6 pm.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. E. Burns, M. D.

Nov 21 1920 (Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ever Green	Nov. 23rd 1920
20 UNDERTAKER	ADDRESS
Mrs J. G. Locke	1302 Jefferson

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48288 HEALTH DEPARTMENT—CITY OF BALTIMORE D-48288

CERTIFICATE OF DEATH

91-041

1-PLACE OF DEATH Bay View Hospital 26 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wright

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) Unknown
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70.			

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bay View Hospital (Address) Balto. Md

15 [illegible] 19 [illegible] Registrar

NOV 22 1920

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Nov. 21, 1920, that I last saw her alive on Nov. 20, 1920, and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Phys. Exam.

(Signed) H. Goldsmith M. D.

11/24/1920 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 24 1920
20 UNDERTAKER	ADDRESS
John M. Toadvine	Westfield Md

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS CERTIFICATE IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D48289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48289

CERTIFICATE OF DEATH.

93-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 W. Fayette ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria C. Hill

(a) RESIDENCE. No. 1011 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Claudius E. Hill

6 DATE OF BIRTH (month, day, and year): June 18, 1846.

7 AGE: Years 74 | Months 5 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Wm Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Haas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Arthur J. Ewen

(Address) 1011 W. Fayette St.

NOV 22 1920

....., 19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-21-1920

17

I HEREBY CERTIFY, That I attended deceased from Nov-14-1920, to Nov-21, 1920, that I last saw her alive on Nov-20, 1920 and that death occurred, on the date stated above, at 3.20 a m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

ODD

(duration) yrs. mos. 7 ds

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Newton D. Parr, M. D.

, 19 (Address) 1530 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Nov 23 1920

20 UNDERTAKER: George J. Smith

ADDRESS: 1000 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous No further infection.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48290

CERTIFICATE OF DEATH.

120 D 48290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 Parkin ST.: 18 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Buckmaster

(a) RESIDENCE. No. 133 Parkin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Buckmaster

6 DATE OF BIRTH (month, day, and year) Unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Buckmaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rebecca L. Buckmaster

(Address) 133 Parkin Ave

NOV 22 1920

ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-20 19

17 I HEREBY CERTIFY, That I attended deceased from 11-19, 19 20, to 11-22, 19 20, that I last saw h— alive on 11-21, 19 20, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic

(duration) Uncertain about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed dingnosis? —

(Signed) Bernard J Fury, M. D.

11/22, 19 20 (Address) 910 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 24 1920
20 UNDERTAKER Eutaw Place Funeral Home	ADDRESS 1600 W Fayette St
George J Smith	

A. B. C.—WRITE PLAINLY, CAREFULLY AND CONFINED WITHIN SPACES. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Over

D48291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48291

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 W. Barre ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Ann Stewart

(a) RESIDENCE. No. 911 W. Barre ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph B. Stewart

6 DATE OF BIRTH (month, day, and year) June 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER Philip Voltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Eliza A. Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Co

14 Informant Carrie L. Stewart

(Address) 911 W. Barre st

15 Filed NOV 22 1920, 19 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to Nov 20, 1920, that I last saw h alive on ....., 19..., and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. 2 wks. ds.

CONTRIBUTORY (Secondary) Fracture hip.

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) T. M. Longerich, M. D

(Address) 826 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Nov. 23 1920
20 UNDERTAKER	ADDRESS
Mrs Mrs John R Templ	801 N Fayette

NOTE—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Head down after ch-
for home.

Spec.—8-24-14—M. & T.—2000 Bks.

D48292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48292

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1403 N. Collington Ave. WARD 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Mrs. Margaret Frederick

(Residence in Baltimore: No. 1403 N. Collington Ave St.; 61 yrs., 1 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, November (Month) 22 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 1 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Trent

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Hebbel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George H. Frederick

(Address) 1403 N. Collington Ave.

15- NOV 22 1920. 191.... Robert B Krauter Registrar. Burial Permit Issued.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1918, to Nov 22 1920, that I saw her alive on Nov 22 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: over

Acute Nephritis.
Cardiac Insufficiency
Years (Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency
(Duration) 1 yrs. 11 mos. 5 ds.

(Signed) Frances A. Carpenter M. D.

Nov. 22 1920 (Address) 2101 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem'l	Nov. 24., 1920

20-UNDERTAKER, Josiah Lyter ADDRESS 1600 W North Ave

Remarks No other abnormal conditions

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Size 6-9-19—H. P. Co.—1000 Rks.

D48293 HEALTH DEPARTMENT—CITY OF BALTIMORE D48293

28

CERTIFICATE OF DEATH.

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4015 Church St. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Norris

(a) RESIDENCE. No. 4015 Church St. ST., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert H. Norris

6 DATE OF BIRTH (month, day, and year) March 6-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel E. McCleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth E. Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Elizabeth E. McCleary (Address) 4015 Church St.

15 Filed NOV 23 1920 ROBERT J. LEASTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1919, to Nov. 21, 1920.

that I last saw h[illegible] alive on Nov. 21, 1920.,

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Ethanolism
(duration) yrs. Few days mos. ds.

CONTRIBUTORY (Secondary) Intoxication (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Dept.

(Signed) D. A. Richards M. D.

Nov. 23 1920 (Address) 114 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Nov. 23 1920
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	363 Hollins St.

IMPORTANT. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48294

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 430 Rosedale Ave. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert W. Fuge

(a) RESIDENCE. No. 430 Rosedale Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 11. 20

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt

(State or country)

PARENTS

10 NAME OF FATHER Louis R Fuge

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Gladwell

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Nella Gladwell

(Address) 430 Rosedale

15 Filed NOV 23 1920 ROBERT B LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1920, to Nov 22, 1920, that I last saw him alive on Nov 19, 1920, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature delivery

a 7½ months (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Jones M. D.

, 19 (Address) Jenkins Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 23 1920
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D18295 HEALTH DEPARTMENT—CITY OF BALTIMORE D48295

150

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1923 N Pratt St. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Pless.

(Residence in Baltimore: No. 1923 N Pratt St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, Nov (Month) 22 (Day), 1920 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 1 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... None
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Pless

11-BIRTHPLACE OF FATHER (State or Country), Hungaria

12-MAIDEN NAME OF MOTHER Susanna Keefer

13-BIRTHPLACE OF MOTHER (State or Country), Hungaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Pless

(Address) 1923 N. Pratt

15- NOV 23 1920 ROBERT B KRAUTER Registrar.

Filed ....., 191.... Burial Permit 01077

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxia Neonatorum

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Prem. Confinement

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D. (Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov 23 1920
20-UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048296

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048296

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 424 N Durham ST.; 6 WARD)

2-FULL NAME James Spann Travis

(a) RESIDENCE. No. 424 N Durham ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Travis

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hospital Orderly

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thos Travis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Addie Travis (Address) 424 N Durham

15 Filed NOV 23 1920 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Nov 20 1920 that I last saw h alive on Nov 19 1920, and that death occurred, on the date stated above, at 2p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs and bones. Prior Gangrene abscess of leg (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Barnes, M. D.

11-21-20 (Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	November 22 1920
20 UNDERTAKER	ADDRESS
Mrs Robert J Elliott	Ashland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

648297 HEALTH DEPARTMENT—CITY OF BALTIMORE 648297

CERTIFICATE OF DEATH.

REGISTERED No. C 24 24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 E. Fort ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles William Elton

(Residence in Baltimore: No. 1416 E. Fort ave St.; 42 yrs. 9 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, January (Month) 25 (Day) 1878 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 9 mos. 27 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer): 686

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Elton

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Amelia Ludwig

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Henrietta Elton

(Address) 1416 E. Fort

15-

Filed NOV 23 1926 191... ROBERT B KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 22 (Day), 1926 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1926, to Nov 22nd 1926, that I saw h.im alive on Nov 21st 1926, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Tumor of Stomach (Duration) 6 mos.

CONTRIBUTORY (Secondary) Hardening of Heart (Duration) 2 yrs. mos. ds.

(Signed) L. L. Leopard M. D.

11/24/26, 191... (Address) 123 E. Fort ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	11/25, 1926
20-UNDERTAKER	**ADDRESS**
J. Finn McCarthy	130 E. Fort ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks following Operation for Fistula

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D48298

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1203 W North ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P Steindler

(a) RESIDENCE. No. 1203 W North Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia Steindler

6 DATE OF BIRTH (month, day, and year) Feb 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired barber

(b) General nature of industry, business, or establishment in which employed (or employer) 104

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER Leopold Steindler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Theresa Fleisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant M A Steindler
(Address) 1203 W North ave

15 Filed NOV 23 1920 19 ROBERT J. BRUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 19 20

17 I HEREBY CERTIFY, That I attended deceased from June, 19 20, to Nov. 22, 19 20, that I last saw h[illegible] alive on Nov. 21, 19 20, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path

(Signed) J Frederick Lenz M. D.

11/22 1920 (Address) 1210 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Nov 24 1920
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, hours or minutes should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Name and address of informant should be given. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048299

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048299

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Mayfield ST.: Rayburg (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Garrity

(a) RESIDENCE. No 105 N. May. ave. ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Edward J. Garrity

6 DATE OF BIRTH (month, day, and year) Nov. 14 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John L. Butt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Adriana Seidle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Edward J. Garrity
(Address) 105 N. May ave

15 Filed ..... 19 ROBERT B. LEAUTER Registrar
Burial Permit Clerk

NOV 23 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-21-1920

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1920, to Nov. 21, 1920, that I last saw h.. alive on Nov. 20, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Laryngitis, Tuberculor

(duration) 2 yrs. 3 (indefinite) mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

11-22-1920 (Address) Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 24 1920

20 UNDERTAKER William L. Schaeffer ADDRESS 816 Monument

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

648300 HEALTH DEPARTMENT—CITY OF BALTIMORE 648300

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 S. Port ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Muck

(Residence in Baltimore: No. 716. South Port St.; 35 yrs., 1 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October (Month) 15 (Day), 1885 (Year)

7-AGE, 35 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Muck

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Katharine Zamanska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Katherine Muck.

(Address) 716 S. Port St.

15- Filed NOV 23 1920, 191... ROBERT B. KRAUTER, Clerk. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Nov 21 1920, that I saw h/m alive on Nov 21st 1920, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert V. Bibley M. D.

Nov 22, 1920 (Address) 100 S. Potomac St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Nov 24th, 1920.

20-UNDERTAKER M. F. Sadowski — ADDRESS 705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48301 HEALTH DEPARTMENT—CITY OF BALTIMORE D48301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1730 Poplar Grove) (in automobile) ST.: 15 (WARD) 175-002

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry V. Gould

(Residence in Baltimore: No. 1730 Poplar Grove St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, May (Month) 11 (Day), 1910 (Year)

7-AGE, 10 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Harry V. Gould

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Anda R. Gould

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. V. Gould

(Address) 1730 Poplar Grove St.

15- NOV 23 1920, 191 ROBERT B KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of skull
(automobile accident)
5 mins (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

Nov. 23, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Church Hill Lawn Cemetery DATE OF BURIAL, Nov 23, 1920

20-UNDERTAKER H. Allen Fuller ADDRESS 3517 Springdale Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1048302 HEALTH DEPARTMENT--CITY OF BALTIMORE 1048302

CERTIFICATE OF DEATH 105

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1807 Frederick ave ST.: 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rhoda B. Hendricks

(Residence in Baltimore: No. 1807 Frederick ave St.: 2 yrs. 10 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Extent of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: fem.

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): single

6-DATE OF BIRTH: January (Month) 23 (Day), 1918 (Year)

7-AGE: 2 yrs. 10 mos. ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Chester F. Hendricks

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Pauline Myrtle Wolf

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F. Hendricks

(Address) 1807 Frederick ave

15 NOV 23 1920 Filed .... 191 ROBERT B. BRAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 22 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 21, 1920, to Nov. 22 1920, that I saw her alive on November 22, 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

acute intestinal indigestion & toxaemia 20m

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Impacted gall stone

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. John Vassalli M. D.

Nov. 22, 1920 (Address) 525 N Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Western Cem

DATE OF BURIAL: Nov 24 1920

20 UNDERTAKER: Rott & Little

ADDRESS: 531 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48303

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1106 Harlem ave ST.; 16 WARD)

2-FULL NAME Helen T McLaughlen

(a) RESIDENCE. No. 1106 Harlem Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feby 22 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	38	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm J. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary E Doyle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

11 Informant Mamie M Laughlin
(Address) 1106 Harlem Ave

15 Filed NOV 23 1920, 19 ROBERT S. BRAUTIGAM Registrar

Burial Permit: Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 19 20

17

I HEREBY CERTIFY, That I attended deceased from Sept 9 20, 19 20, to Nov 21, 19 20.

that I last saw h[er] alive on Nov 21, 19 20,

and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY .....
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Sept. 8. 20

Was there an autopsy? No

What test confirmed diagnosis? Pathological Exam

(Signed) J. J. Kirby, M. D.

, 19 (Address) 1106 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	11-24-1920
20 UNDERTAKER	ADDRESS 517 N.
H. Browning Son	Schroeder St

be stated EXACTLY. INSTRUCTIONS.—Should state
be properly classified. Exact statement of OCCUPA-
of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec. 6-9-19—H. P. Co.—1000 Bks.

048304 HEALTH DEPARTMENT—CITY OF BALTIMORE 048304

CERTIFICATE OF DEATH. 122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4017 Springdale Ave ST.: Forrest Park 15 WARD)

2-FULL NAME Henry R. Wahl

(a) RESIDENCE. No. 4017 Springdale Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Wahl

6 DATE OF BIRTH (month, day, and year) Oct 29 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Salomon Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Gustorff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry Hamburger 4012 Springdale Ave

15 Filed NOV 23 1920 19 ROBERT B. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920 to Nov 23rd 1920, that I last saw him alive on Nov 21st 1920, and that death occurred, on the date stated above, at 5 40 A. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopical Examination

(Signed) A. C. Bunch, M. D.

(Address) 4109 Reisterstown Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Nov 24 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

MAKE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48305

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1830 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles James

(a) RESIDENCE. No. 1830 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna James

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Isaac A Sheppard

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna James (Address) 1830 N. Caroline St.

15 Filed NOV 23 1920 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1919, to Nov. 20, 1920, that I last saw h[illegible] alive on Nov. 20 1920, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederick Lee, M. D.

11/21, 1920 (Address) 7040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 24 1920
20 UNDERTAKER	ADDRESS
H. Gander & Son	1710 Fleet St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 48306 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Boat of Kenwood St.: 23 Ward) 17

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carlton C Johnson Jr

(Residence in Baltimore: No. 110 W Lanvale St.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 11, 1902
(Month) (Day) (Year)

7-AGE, 17 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper
(b) General nature of industry, business, or establishment in which employed (or employer): O&C

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Carlton C Johnson Senr

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Edna C Hawley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlton C Johnson

(Address) 110 W Lanvale St

15- Filed NOV 23 1920, 191.... ROBERT B [illegible] Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally killed by fall from scaffold & fractured skull.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H Kelly Ryan M. D.
(Coroner)
Nov 23, 1920 (Address) 1502 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem.	Nov. 23, 1920
20-UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48307

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED No. C

CITY OF BALTIMORE: (No. North Broadway ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Josephine Robal

(Residence in Baltimore: No. 215 Duncan St. City St.; 36 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 22 (Month) (Day) 1884 (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Novotny

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant Lanon

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robal

(Address) 215 Duncan St

15-

Filed NOV 23 1920, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1920, to Nov. 22, 1920, that I saw h[illegible] alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction probable,
due to Post Operative Adhesions

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter T. Anderson M. D.

Nov 22, 1920 (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State all her life yrs. mos. ds.

Where was disease contracted, if not at place of death? 215 Duncan St. City

Former or usual residence 215 Duncan St. City.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Nov 25, 1920

20-UNDERTAKER Funk & Zrack Sons

ADDRESS Madison Blvd

Spec.—6-9-19—H. P. Co.—1000 Eks.

D.48308 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48308

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 918 St. Paul St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Pym Remington

(a) RESIDENCE. No. 918 St. Paul ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Single

6 DATE OF BIRTH (month, day, and year) Aug 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Wm Remington

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pa.

12 MAIDEN NAME OF MOTHER Caroline Williams

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant George H. Gross (Address) 30 E. Biddle St.

15 Filed NOV 23 1920 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Nov 22 1920, that I last saw h[illegible] alive on Nov 20 1920, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Embolus (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) George H Gross, M. D.

, 19 (Address) 30 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 24 1920
20 UNDERTAKER Henry Heuisler & Co	ADDRESS Mt. Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48309 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48309

160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 50 Ida Hospital ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Thau

(Residence in Baltimore: No. 608 n Gay St.; 33 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Colt	Single

6-DATE OF BIRTH, Feb 15th, 1895
(Month) (Day) (Year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Auto mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER. Mathias Thau

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Amelia Himmelsbach

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathias Thau

(Address) 5911 Belvedere Ave

15- Robert P. Harrison,
Filed NOV 23 1920, 191.....
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stabbed by Cutlers

Throat (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Bowles M. D.
(Coroner.)

(Address) 11 S. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pinewood Cem	Nov 23rd, 1920

20-UNDERTAKER	ADDRESS
Jos. G. Cook	North & Harford Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.48310 ✓D.48310

D.48310 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 26 WARD)

2-FULL NAME Harry Burton

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frankford, Delaware

PARENTS

10 NAME OF FATHER Archer Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frankford, Delaware

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frankford, Delaware

14 Informant (Address) Hospital Records, New City Hospital,

15 Filed NOV 23 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1920, to November 17, 1920, that I last saw him alive on November 17, 1920, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

1B. Fecal fistula
(Post-operative)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage + shock
(duration) yrs. mos. 3 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11-17-20

Was there an autopsy? —

What test confirmed diagnosis? Laparatomy

(Signed) F A Holden, M. D.

11/17/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health,	ADDRESS NOV 23

Reg. Wm. F. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48311 ✓ 20.48311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gardner.

(a) RESIDENCE. NO. Unknown. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Unknown.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850(?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70(?)			

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work Unknown,

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Records.
(Address) City Hospital, Bay View

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1919, to Nov. 21, 1920, that I last saw her alive on Nov. 21, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage) (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) P. Sherman, M. D.

11-22-1920 (Address) City Hospital Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

ADDRESS NOV 23

20 UNDERTAKER

Commissioner Health.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

35-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48312

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 N. Eden ST.: 9 WARD)

2-FULL NAME Daniel Malone

(a) RESIDENCE. No. 1432 N. Eden ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christina Malone

6 DATE OF BIRTH (month, day, and year): Oct - 1834

7 AGE: 86 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer): Policeman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Daniel Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rose Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Christina Malone

(Address) 1432 N. Eden St.

15 [illegible]

NOV 23 1920

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21. 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to Nov. 21. 1920, that I last saw h[illegible] alive on " 20, 1920, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

(a) Senility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic - sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Not any

(Signed) George A. Hartman, M. D.

Nov. 22, 1920 (Address) 2214 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov. 24 1920
20 UNDERTAKER	ADDRESS
H. C. Windfield	704 Gremmel Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.48313 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48313

CERTIFICATE OF DEATH.

REGISTERED NO. C 21 91-069

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1155 Carroll ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME alfred Reinehart

(Residence in Baltimore: No. 1155 Carroll, St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, April (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (00)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank Reinehart

11-BIRTHPLACE OF FATHER (State or Country), Carlisle Pa

12-MAIDEN NAME OF MOTHER Sarah Culbertson

13-BIRTHPLACE OF MOTHER (State or Country), Bethlemtown Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr F. Reinehart

(Address) 1155 Carroll st

15. NOV 23 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18 1920, to Nov. 23 1920 that I saw h[illegible] alive on Nov 23 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: (00)

Bronchopneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ....yrs. ....mos. 8 ds.

(Signed) John Addison Shy M. D.

Nov 23, 191.. (Address) 638 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1155 Carroll St

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Nov 25., 1920

20-UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48314 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 261 Robert St.: 14th WARD) REGISTERED NO. 90

2-FULL NAME Hannah Elizabeth McComas

(a) RESIDENCE. No. 261 Robert St., WARD. (Bel-Air-Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., If of foreign birth? 82 yrs. 11 mos. 27 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Exact Matching of OCCUPATION should be stated EXACTLY. THE WORDS "laborer," "housewife," "clerk," "manufacturer," "merchant," or "dealer" should not be used unless they may be properly classified. AGE should be carefully supplied. AGE should be stated in YEARS, months and days. Exact Matching of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander McComas

6 DATE OF BIRTH (month, day, and year) Nov-25-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Jarrettsville (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER William Vanty

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Vanty

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country)

14 Informant Mrs Chas F. McComas (Daughter in Law) (Address) 261 Robert St. Robert P. Harrison,

15 Filed NOV 23 1920 19 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 22nd, 1920, to Nov 22nd, 1920, that I last saw her alive on Nov 22nd, 1920, and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

A general neuro-cardiac breakdown

Contributory (Secondary) Probably an attack of Grippe 4 years ago (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo H. Comas, M. D.

, 19 (Address) 214 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bel-Air Md. DATE OF BURIAL: Nov 24 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48315 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48315

CERTIFICATE OF DEATH.

76

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 743 W. McHenry ST. 21 WARD)

2-FULL NAME Ethel Loraine Greenwaldt

(a) RESIDENCE. NO. 743 W. McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		Eleven	1.	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto- Maryland

PARENTS

10 NAME OF FATHER Chas Greenwaldt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto- Maryland

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas Greenwaldt (Address) 743 W. McHenry St

15 Filed 23 1920 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Nov 22, 1920 that I last saw her alive on Nov 22 1920 and that death occurred, on the date stated above, at 6.10 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Otitis media (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Fuhrmeyer M. D.

11/23/20 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph	Nov 24 1920
20 UNDERTAKER	ADDRESS
Mr & Mrs Bond	1935 N Bond

(over)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48316 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 E. Lombard St.; 2~~5~~9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mary Link

(Residence in Baltimore: No. 1936 E. Lombard St.; 4 yrs., 7 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, March 24, 1916.
(Month) (Day) (Year)

7-AGE, 4 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): ppl

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John A. Link

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Werneburg

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Link

(Address) 1936 E. Lombard St.

15- NOV 23 1920 Robert P. Harrison, 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21 1920, to Nov. 23 1920, that I saw her alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Eugene L. Pessano M. D.

Nov. 23, 1920 (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 24, 1920

20-UNDERTAKER Wendell Ruppel & Son — ADDRESS 37 S ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48317 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. University Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Bradley.

(Residence in Baltimore: No. Dundalk Md. #36 Township Road St.; ..... yrs., ... mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... dont know ..... (Month) ..... (Day), 1858 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Maryland. Germany.

PARENTS.

10-NAME OF FATHER, John Vogel.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D. Bradley

(Address) 36 Township Rd. Dundalk

15- NOV 23 1920 Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 21 1920, that I saw her alive on Nov. 21 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

..... (Duration) ..... yrs. ..... mos. 1½ ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. L. Wilson M. D.

....., 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State 62 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Dundalk Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	Nov. 24, 1920

20-UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

(over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48318 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Prattr schroder- ST.: 18 181 WARD) REGISTERED No. C .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. H DOR-
(Residence in Baltimore: No. 853 W Lombard St.; yrs., mos. ds.)

Life

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: ..... Don't Know; 1 ..... (Month) (Day) (Year)

7-AGE: ..... 30 ..... yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boiler maker
(b) General nature of industry, business, or establishment in which employed (or employer): Ship

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Frank Dorr,

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Alice Hughes.

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Alice Dorr
(Address) 853 W. Lombard St

15- Filed NOV 23 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov ..... 21 ....., 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted

At ..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. 9 mos. ..... ds.

(Signed) W. B. Forrest M. D. (Coroner.)

Nov 22 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Nov 24 1920

20-UNDERTAKER Joseph B Cook — ADDRESS 100 S. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48319

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48319

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2031 Booth St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sovettah E. Evans

(a) RESIDENCE. No. 2031 Booth St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Evans

6 DATE OF BIRTH (month, day, and year) Mar, 21, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer 637

9 BIRTHPLACE (city or town) (State or country) Loudon Co Virginia

PARENTS

10 NAME OF FATHER James J. Cockrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudon Co, Virginia

12 MAIDEN NAME OF MOTHER Amelia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Loudon Co. Virginia

14 Informant William H Evans
(Address) 2031 Booth St

15 Filed Robert P. Harrison, Registrar

NOV 23 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov, 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov, 18, 1920, to Nov, 21, 1920, that I last saw h alive on Nov, 21, 1920, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Davis Trueblum M. D.

11/23, 19 (Address) 122 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 24 1920
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W Balto St

information should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

CCUPA-

ct statements

at it may be properly classified. F

s on back of certificates.

D.48320 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48320

CERTIFICATE OF DEATH. X 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Rogers Ave & N. So. Bend Av St. 27 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Slofer

(Residence in Baltimore: No. Rogers Ave & N. So. Bend Av St.; yrs., 2 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, March 5, 1845 (Month) (Day) (Year)

7-AGE, 75 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Adam Slofer

11-BIRTHPLACE OF FATHER (State or Country), Adam Co. Pa

12-MAIDEN NAME OF MOTHER, Elyabeth Bruer

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George B Foner

(Address) Camp Hill Pa

15- Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over

Accident

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) John Foreman, M. D. (Coroner.)

Nov 23 1920, (Address) 3402 Rogers Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence Harrisburg Pa.

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Harrisburg Pa	Nov 24, 1920

20-UNDERTAKER P S Marshall ADDRESS 3539 Fall Rd

D.48321 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48321

CERTIFICATE OF DEATH.

167

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth B. Murray.

(Residence in Baltimore: No. Taylor Ave Fullmore St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Jan. 23 ....., 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher 068
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, James B. Murray

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Helen Ryan

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. H. London

(Address) 2854 Overland Ave

15- Robert P. Harrison,

NOV 23 1920 ....., 191.....

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, upset Oil

Nurse (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knott Lindsay M.D.
(Coroner.)

11-23, 192 (Address) 49 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Nov 24, 1920

20-UNDERTAKER W. J. Tickner & Son

ADDRESS North & Penna

N.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48322 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 175-001

CITY OF BALTIMORE (No. Mercy Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Farrell

(Residence in Baltimore: No. Mercy Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.)
Male	W.	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1..... (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Inspector R.R.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 63

9-BIRTHPLACE, (State or Country) A.A. Co Md

PARENTS.

10-NAME OF FATHER, Alfred Farrell

11-BIRTHPLACE OF FATHER (State or Country) A.A. Co Md

12-MAIDEN NAME OF MOTHER Mary J. Feeney

13-BIRTHPLACE OF MOTHER (State or Country), A.A. Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace Farrell

(Address).....

15- Robert P. Harrison,

Filed ....., 191..... Burial Permit Clerk. Registrar.

NOV 23 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injury A Foot Accident

Pulmonary Embolism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 7 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? A.A. Co Md

Former or usual residence Odenton Md.

19-PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL,
Odenton Md	Nov 24, 1920
20-UNDERTAKER	ADDRESS
H. T. Dickey	Odenton Md

19—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48323 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1239 N. North ave ST.; 14 WARD)

REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Josephine Vail

(a) RESIDENCE. No. 1239 N. North ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Monzo F. Vail

6 DATE OF BIRTH (month, day, and year): June 12 1844

7 AGE: Years 76 Months 5 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Middletown Conn.

PARENTS

10 NAME OF FATHER: Edw Burdett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Middletown Conn

12 MAIDEN NAME OF MOTHER: Hulda Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Connecticut

14 Informant: Fred B. Vail
(Address): 2408 Guilford ave

15 Filed NOV 23 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1920, to Nov 23, 1920, that I last saw h[illegible] alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? H

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jno Ehrlich, M. D.

19 (Address) 714 W N Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: River Head NY — DATE OF BURIAL: Nov 24 1920

20 UNDERTAKER: Fred J. Pusey & Sons — ADDRESS: North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14387 D.48324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48324

CERTIFICATE OF DEATH.

+53

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R White

(a) RESIDENCE. NO. Leesburg Va. ST., WARD. Point of Rocks Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 / 853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anne C. Foulton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J.H.H. Records.
(Address)

15 Filed NOV 29 1920, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Nov 23, 1920

that I last saw h~~im~~ alive on Nov 23, 1920,

and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. R. Mason, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Point of Rocks Md.	Nov. 24 1920
20 UNDERTAKER	ADDRESS
H. Allen Fuller	2517 Eyrsdale Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048325

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048325

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Spring Hill Ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma G. Caldwell

(a) RESIDENCE. NO. 2704 Spring Hill Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. 7 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of George Caldwell

6 DATE OF BIRTH (month, day, and year) March 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER James Kyle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Ferrar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mr George Caldwell husband
(Address) 2704 Spring Hill Ave

15 NOV 24 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1920, to Nov. 22, 1920, that I last saw h[illegible] alive on Nov. 21, 1920, and that death occurred, on the date stated above, at 3 P. M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Equirock M. D.

. 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 26 1920
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons	1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48326 HEALTH DEPARTMENT—CITY OF BALTIMORE D48326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1214 Ething St, St. 17 Ward) REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Eckles

(a) RESIDENCE. No. 1214 Ething St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella A. Eckles

6 DATE OF BIRTH (month, day, and year) Nov. 11-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) retired. 046

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fulton Co. Pa

PARENTS

10 NAME OF FATHER John Eckles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lillian Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Ella A. Eckles Wife
(Address) 1214 Ething Street

15 Filed NOV 24 1920 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to Nov 22, 1920, that I last saw him alive on Nov 21, 1920, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical symptoms

(Signed) Edw. J. Fitzgerald, M. D.

, 19 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Nov. 25 1920
20 UNDERTAKER	ADDRESS
Jno. McGorvey	1234 Ething St.

NOTE.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Baby Lee

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48327

CERTIFICATE OF DEATH.

151 D48327

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1011 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Lee

(Residence in Baltimore: No. 1011 McCulloh St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Nov. 20th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.
If LESS than 1 day, 12 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) 1011 McCulloh St.

PARENTS.

10-NAME OF FATHER. Henry Lee

11-BIRTHPLACE OF FATHER (State or Country). China

12-MAIDEN NAME OF MOTHER Ida Moore

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Lee

(Address) 1011 McCulloh St.

15-

Filed NOV 24 1920, 191.... DISTRICT REGISTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21st, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20th 1920, to Nov. 21st 1920, that I saw h[illegible] alive on Nov. 21st 1920, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5 Months Gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hydramnios

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

11/21, 191.. (Address) 32 Woodyard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Nov. 24, 1920
20-UNDERTAKER Paul Eversfield	ADDRESS 916 Pa Ave

Spec. 6-9-19—H. P. Co.—1069 Blks.

D48328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D48328

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 838 Edmondson Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Johnson

(a) RESIDENCE. No. 838 Edmondson ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha C. Johnson

6 DATE OF BIRTH (month, day, and year) January 10. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk city Court

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rachael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) england

14 Informant Bertha C. Johnson
(Address) 838 Edmondson ave

15 Filed NOV 24 1920 Registrar John Oldfield

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Nov 22, 1920, that I last saw h[illegible] alive on Nov 22, 1920, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. days

18 Where was disease contracted if not at place of death? 3

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ordinary urine tests

(Signed) Irwin Eshenaur, M. D.

Nov 24 1920 (Address) 710 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Le Park.	Nov. 24 1920
20 UNDERTAKER	ADDRESS
John Oldfield & Son	1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D48329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D48329

1 PLACE OF DEATH

REGISTERED No. C 642

CITY OF BALTIMORE (No. 2613 N. Calvert St. ST. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura A. Wellham

(Residence in Baltimore: No. 2613 N. Calvert St. 63 yrs. 1 mos 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): single

6 DATE OF BIRTH: Oct 4, 1857 (Month) (Day) (Year)

7 AGE: 63 yrs. 1 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: house duties
(b) General nature of industry, business, or establishment in which employed (or employer): do

9 BIRTHPLACE (State or country): Balto md

PARENTS

10 NAME OF FATHER: Hezekiah Wellham

11 BIRTHPLACE OF FATHER (State or country): A. A. Co Md

12 MAIDEN NAME OF MOTHER: May A. Hammond

13 BIRTHPLACE OF MOTHER (State or country): A. A. Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Wellham

(Address) 2613 N. Calvert St

15 NOV 24 1920 Filed ....., 191.... ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 23, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1920, to, Nov 23 1920 that I saw h-er alive on Nov 23, 1920, and that death occurred, on the date stated above, at 11.45 a m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 6 hours

Contributory (SECONDARY) Acute Indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Talbot M. D.

Nov 23, 1920. (Address) 2413 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lo Park

DATE OF BURIAL: Nov. 26, 1920

20 UNDERTAKER: John Ouellette

ADDRESS: 200 Watson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 48330 — 79 D 48330

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1209 Eutaw Place St. 11 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Austin C Stoneburner

(Residence in Baltimore: No. 1209 Eutaw Place St.: 57 yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April 11 (Month), 11 (Day), 1861 (Year)

7-AGE: 59 yrs. 7 mos. 11 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: Jacob C. Stoneburner

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Charlotte E.

13-BIRTHPLACE OF MOTHER (State or country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lola A. Stoneburner

(Address) 1209 Eutaw Place

NOV 24 1920 Filed, 191

ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 22 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1916, to Nov 22 1920.

that I saw him alive on Nov. 4 1920.

and that death occurred, on the date stated above, at 1.15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.
Mitral Insufficiency

(Duration) 15 yrs. .... mos. .... ds

Contributory (SECONDARY) ..... (Duration) .... yrs. .... mos. .... ds.

(Signed), S Downs M. D.

Nov 22, 1920 (Address) 1133 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery | DATE OF BURIAL: Nov 24, 1920

20-UNDERTAKER: John C. Mitchell | ADDRESS: 120 W Fayette

Spec. 6-9-19—H. P. Co.—1000 Bks.

D48331 HEALTH DEPARTMENT—CITY OF BALTIMORE D48331

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N Smallwood ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. W Hipsley

(a) RESIDENCE. No. 104 N Smallwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20- 1920

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wilbur Hipsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Agnes Cunrid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Marg Cunrid (aunt)
(Address)

15 Filed NOV 24 1920 ROBERT B KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 22nd 20 to Nov 23rd 20.

that I last saw him alive on Nov 22nd 20.

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ray. O. McCleary, M. D.

11/24/20 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 25 19

20 UNDERTAKER: George J. Smith — ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48332

CERTIFICATE OF DEATH.

REGISTERED No. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Edward Harrigan

(a) RESIDENCE. No. 2909 St Paul St. ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Eight

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 63

(b) General nature of industry, business, or establishment in which employed (or employer) News paper work -

(c) Name of employer Sun.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 FILED NOV 24 1920 ROBERT B. KRUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1920, to Nov 23rd, 1920, that I last saw h alive on Nov 22nd, 1920, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis -

(duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Psychoasthenia -

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Nov 23, 1920 (Address) Mt Hope Retreat - Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/26 1920

20 UNDERTAKER Chas F. Evans & Son 118 W. ADDRESS Mt. Royal

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 48333 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 48333

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1636 Thames ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Lema

(Residence in Baltimore: No. 1636 Thames

unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, About ....., 1892
(Month) (Day) (Year)

7-AGE, 28 About yrs. mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Mexico

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Seamen & Firemen Assoc.

(Address) 812 S. Broadway.

15- Filed NOV 24 1920, 191.....

ROBERT B KRAUSER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22", 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

11/24, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincent's Cem.	11/24, 19.20
20-UNDERTAKER C.F.Evans & Son-	ADDRESS 118 W. Mt Royal Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D148334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D148334

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Fontaine St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Carroll

(Residence in Baltimore: No. 1118 Fontaine St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	col	Wid'd

6-DATE OF BIRTH, ...Mar..... (Month) 3 (Day) 18[illegible] (Year)

7-AGE, 87 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Fred Carroll

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Alice Chew

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Carroll

(Address) 1118 Fontaine St

15- Filed NOV 24 1920, 191.... ROBERT F KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 1920, to Nov. 20 1920, that I saw h[illegible] alive on Nov. 20 1920, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs....mos....ds.

(Signed) David E. Wilmer M. D.

Nov 24, 1920. (Address) 1126 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel cem. DATE OF BURIAL, Nov 24, 1920

20-UNDERTAKER Mrs Robt Ellis ADDRESS 1125 Eastland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48335 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D48335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1345 Pennsylvania Ave ST. 17 WARD)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Monahan

(Residence in Baltimore: No. 1345 Pennsylvania Ave St.; 79 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Feb. (Month) 6 (Day), 1841 (Year)

7-AGE, 79 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frederick J. Monahan

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Amelia Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Schmidt

(Address) 104 St. Johns Rd, Roland Park

15- Filed NOV 24 1920, 191.... ROBERT E. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy M. D. (Coroner.)

Nov. 23 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Nov. 25, 1920

20-UNDERTAKER Martin Fahey Son — ADDRESS 827 N. Howard St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D48336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 Oct Sunday 24 C.B. D48336

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 - Fait ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Bullmer

(Residence in Baltimore: No. 3504 - Fait ave St.; ....yrs.,....mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, 11 (Month) 24 (Day), 1920 (Year)

7-AGE, ...yrs. 21 mos. ....ds.	If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Julian H Bullmer

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co.

12-MAIDEN NAME OF MOTHER Barbara Zeller

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H Bullmer

(Address) 3504 - Fait ave

15- NOV 24 1920

Filed....., 191.... ROBERT P. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/24 1920, to 11/24 1920, that I saw h[illegible] alive on ....191....., and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Accidental suffocation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Accidental suffocation

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Farrell M. D.

11/24, 1920 (Address) 633-5-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem.	Nov. 24, 1920.
20-UNDERTAKER Lilly and Feiler	ADDRESS 403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Summerset (Morrell Pk) ST.; 25 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H Moody

(Residence in Baltimore: No. Summerset St.; 1 yrs., 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, April (Month) 15 (Day), 1919 (Year)

7-AGE, 1 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William A. Moody

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth R Miller

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Woody

(Address) Samarset St

15-

Filed NOV 24 1920, 191.....

Registrar.

Burial Permit Sheet

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Nov 23 1920, that I saw him alive on Nov 23 1920, and that death occurred, on the date stated above, at 7.50 P.m.

The CAUSE OF DEATH* was as follows:

chronic Cronit Nephr

.....

.....

..... (Duration).....yrs.....mos. 24 ds.

CONTRIBUTORY (Secondary) Asthypsia

..... (Duration).....yrs.....mos.....ds.

(Signed) Thos B. Hall M. D.

(11-24-, 1920 (Address) Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Leader Hill Cem — DATE OF BURIAL, Nov 24, 1920

20-UNDERTAKER G H Mellor Son — ADDRESS 1218 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48338 HEALTH DEPARTMENT—CITY OF BALTIMORE D48338

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 3rd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Prime

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,

(Address) New City Hospital.

15 Filed NOV 24 1920 ROBERT I KRAUTER Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1920, to November 22 1920, that I last saw him alive on November 21, 1920, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical.

(Signed) Patterman M. D.

11/23/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Cemetery	Nov 24 1920
20 UNDERTAKER	ADDRESS
Robt J Turner Sr	1424 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48339

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Darley Ave. St. 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy R. Garrett Jr.

(a) RESIDENCE. NO. 1701 Darley Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 9- 1919

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None yet

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Guy R. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Ida L. Chatwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant Guy R. Garrett

(Address) 1701 Darley Ave

15 Filed NOV 24 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22/20

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1920, to Nov 22, 1920, that I last saw h[illegible] alive on Nov 22, 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Convulsions.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Extra Uterine

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptoms.

(Signed) J. A. Blades, M. D.

(Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11/24 1920

20 UNDERTAKER J. A. Inman

ADDRESS 30 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and UNDERTAKERS should see that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D48340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48340

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Gelston Ct ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Bailey

(a) RESIDENCE. No. 1033 Gelston Ct ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE — Years: 47 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joshua Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hester Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hester J Bailey

(Address): 1033 Gelston Ct

15 Filed NOV 24 1920 19 ROBERT B KRAUTER Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 22, 1920, that I last saw h— alive on Nov 21, 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Norwood M. D.

(Address) 939 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel [redacted]	Nov 26 1920
20 UNDERTAKER	ADDRESS
Sam'l W. Chase Son	1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

O'Brien

Spec. 6-9-19—H. P. Co.—1000 Blks.

D48341 HEALTH DEPARTMENT—CITY OF BALTIMORE D48341

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 536 McMechen St. 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ohiza

(a) RESIDENCE. No. 536 McMechen ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson Potter

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Julia Dolton
(Address) 536 McMechen

15 Filed NOV 24 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 22, 1920, that I last saw h alive on Nov 22, 1920, and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) R. Gaines Chisholm, M. D.

Nov 23 1920 (Address) 1534 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Nov 26 1920
20 UNDERTAKER George H. Holland	ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. 048342

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 So. Bradford ST.: 1 WARD)

2-FULL NAME Alexandra Pietrzyk

(a) RESIDENCE. No. 608 So. Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 + yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Pietrzyk

6 DATE OF BIRTH (month, day, and year) July - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Kowalewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Otola Synarowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Pietrzyk (Address) 608 S. Bradford St

15 NOV 24 1920 ROBERT B KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Nov. 22, 1920, that I last saw her alive on Nov 22, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Starvation, Homicidal (over)

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) dementia praecox

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about Aug. 20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Horak, M. D.

, 19 (Address) 821 N. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Nov 25 '20
20 UNDERTAKER	ADDRESS
M. F. Sadowski	905 S. Linwood

Station should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1048343 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048343

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 933 Park Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt G. Chase

(Residence in Baltimore: No. 933 Park Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Marr

6-DATE OF BIRTH, Feb 20, (Month) (Day) 1 (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Estes Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M

(Address) Home

NOV 24 1920 ROBERT B KRAUTER

Filed ....., 191... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(Duration) yrs. mos. ds.

(Signed) G. Lee Blades M. D.
(Coroner)
11/23, 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cathedral | DATE OF BURIAL, Nov 26, 1920.

20-UNDERTAKER Felix B. Lyle | ADDRESS 103 E. Mulberry St.

Spec.—8-24-14—M. & T.—2000 Bks.

D48344 HEALTH DEPARTMENT—CITY OF BALTIMORE 40 D48344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 6017 Foster ave Govans St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Lewis Tawney

(Residence in Baltimore: No. 6017 Foster ave Govans St.; 2 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, June (Month) 20 (Day), 1851 (Year)

7-AGE. 69 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Self. g/o

9-BIRTHPLACE. (State or Country), md

PARENTS.

10-NAME OF FATHER, Thomas D. Tawney

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Elizabeth Tracey

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carrie Tawney

(Address) 6017 Foster ave Govans

15- Filed NOV 24 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit 01471

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1920, to Nov 23 1920, that I saw h.im alive on Nov 22 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Duncan M. D.

Nov 23, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Grace M. P. Cem. Govans Baltimore Co	NOV 26 1920
20-UNDERTAKER	ADDRESS
John Burns Sons	Govans

Spec.—8-24-14—M. & T.—2000 Bks.

D48345 HEALTH DEPARTMENT—CITY OF BALTIMORE D48345

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. 15 th. St.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Garvin

(Residence in Baltimore: No. 622 S. 15 th St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 18, 1895
(Month) (Day) (Year)

7-AGE, 25 yrs. 4 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Bell

9-BIRTHPLACE, (State or Country), Hagerstown Md.

PARENTS.

10-NAME OF FATHER, William Garvin

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Laura Moore

13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Garvin

(Address) 622 S. 15 th St.

15-

Filed ....., 191.... ROBERT B BEAUTER
Registrar.
NOV 24 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23, 20, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 20 191..., to Nov 23 20 191..., that I saw h.m alive on Nov 22 20 191..., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Warren M. D.

Nov 23, 191... (Address) 916 S Bdwy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hagerstown, Md.	Nov. 24, 1920.

20-UNDERTAKER	ADDRESS
H Sonder & Son	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-48346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-48346

REGISTERED NO. 3 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Duckett

(a) RESIDENCE. No. 1002 Salisbury Alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed NOV 24 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 19, 1920, to November 23 1920, that I last saw her alive on November 22, 1920, and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic pulmonary tubercu-
losis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V Bateman. M. D.

11/23/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	11/24 1920
20 UNDERTAKER	ADDRESS
Chas G Bailey	1421 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048347

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048347

CERTIFICATE OF DEATH.

91-081

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Watkins

(a) RESIDENCE. No. ~~Un~~known ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed NOV 24 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1919, to November 21 1920. that I last saw h im alive on November 21, 1920, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis
(No cerebral hemorrhage)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical

(Signed) H. A. Newman M. D.

11/22/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	Nov 24 1920
20 UNDERTAKER Edmund Hunday	ADDRESS 618 N Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wormley.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048348 HEALTH DEPARTMENT—CITY OF BALTIMORE 048348

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St. 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Wormley

(a) RESIDENCE. No. 1531 N. Spring St., St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown. First (Tolen)

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home Baltimore.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Blake Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Alice M. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Chas B. Jones

(Address): 1531 N. Spring Ave

15 Filed NOV 24 1920 19 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 19 20, to Nov 21, 19 20

that I last saw h. Er alive on Nov 21, 19 20.

and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (Left)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) F. C. Marine, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Nov 25 19 20

20 UNDERTAKER: Arnold Hensley

ADDRESS 518 N. Bradford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048349 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048349

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

2-FULL NAME Mr. George Keenan

(a) RESIDENCE. No. Bangor, Pa ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Slate Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER James Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Geo Keenan
(Address) Bangor Pa

15 NOV 24 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24 1920

17 I HEREBY CERTIFY, That I attended deceased from 11-4, 1920, to 11-24, 1920, that I last saw him alive on 11-24, 1920, and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Left- Hemiplegia

"T. Operation"

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Meaning

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 11/20/20

Was there an autopsy? Yes.

What test confirmed diagnosis? Tumor Confirmed

(Signed) J. F. Weaver, M. D.

1920 (Address) 80 W Caldwell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shulpsburg N Y	Nov 26 1920
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	17 E Caldwell

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48350 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48350

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 314 N Greene St. (WARD) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Bradford.

3-Residence in Baltimore: No. 314 N Greene St. (St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Single

6-DATE OF BIRTH, Nov. 5, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 18 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Granville Bradford

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Blanche Broady

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Granville Bradford

(Address) 314 N Greene

15- Robert P. Harrison,

Filed NOV 24 1920, 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ her death on the day stated above.

The ~~CAUSE OF DEATH~~* was as follows:

Gastro Enteritis

(Duration) ....yrs. .... mos. 16 ds.

CONTRIBUTORY (Secondary) Could not retain or digest food

(Duration) ....yrs. ....mos. ....ds.

(Signed) W F Guy M. D. (Coroner.)

11-24, 1920 (Address) 17 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Nov 25, 1920
20-UNDERTAKER H M Routson	ADDRESS 230 N Greene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48351

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 78 S. Curley St. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gummer.

(a) RESIDENCE. NO. 78 S. Curley ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed. Andrew Gummer.

6 DATE OF BIRTH (month, day, and year): June 3 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Rosenmueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant (Address): Mrs. Margaret Wagner. 75 20 Fait. Ave

15 Filed NOV 24 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 19 17, to Nov. 22nd, 19 20,

that I last saw her alive on Nov. 22nd, 19 20,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Arterio-Sclerosis

(duration) 4 yrs. - mos. - ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Fitzgerald, M. D.

11/24, 19 20 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov. 25 1920
20 UNDERTAKER: Libby and Zile	ADDRESS: 403 W. Fay.

REFER SHOULD BE STATED EXACTLY. Indefinite terms such as "Heart Disease," "Cancer," "Consumption," "Pneumonia," "Kidney Disease," "Paralysis," "Old Age," "Accident," "Fracture," "Drowning," "Burns," "Homicide," "Suicide," "Abortion," "Childbirth," "Malpractice," "Convulsions," "Fever," "Infection," "Septicemia," "Blood Poisoning," "Tuberculosis," "Meningitis," "Hemorrhage," "Dropsy," "Debility," "Senility," "Unknown," "Not Known," "Not Stated," "Not Ascertained," "Not Diagnosed," "Not Known to Informant," "Not Known to Me," "Not Known to Physician," "Not Known to Coroner," "Not Known to Undertaker," "Not Known to Embalmer," "Not Known to Sexton," "Not Known to Grave Digger," "Not Known to Cemetery Superintendent," "Not Known to Anyone

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48352 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48352

CERTIFICATE OF DEATH.

79-091 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Josephs Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John L. Mum

(a) RESIDENCE. NO. 403 S. 15th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowered

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Mum

6 DATE OF BIRTH (month, day, and year) Nov 11 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68	—	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist. 031
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Troy N Y
(State or country)

PARENTS

10 NAME OF FATHER John Mum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Mrs Katherine Kennedy
(Address) 410 Maple Ave Elmira N Y

15 Filed NOV 24 1920 19 Robert P. Harris
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov 23, 19 20, that I last saw h[illegible] alive on Nov. 23, 1920, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings. Physical Signs

(Signed) Chas. O'Donovan, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 24 1920
20 UNDERTAKER John Deering & Co	ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.--8-24-14—M. & T.—2000 Bks.

D.48353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48353

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1808 Bolton ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry P. Crook

(Residence in Baltimore: No. 1808 Bolton St.; 22 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Widower

6-DATE OF BIRTH. ..... Jan (Month) 8 (Day), 1862 (Year)

7-AGE. 57 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Traveling
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Salesman

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Victor V. Crook

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Georgiana Elkenhead

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry P. Crook Jr.

(Address) 1808 Bolton St

15-

NOV 24 1920

(Signature) Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 24 Nov 1920, to 24 Nov 1920, that I saw him alive on 24 November 1920, and that death occurred, on the date stated above, at 5-20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Horace W. Byers M. D.

24 Nov., 1920 (Address) 749 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Nov 26 1920
20-UNDERTAKER Geo J. Smith	ADDRESS 1000 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48354 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48354

CERTIFICATE OF DEATH. X 175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Beidler & Sellman ST.: 17th WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J. Markey.

3-Residence in Baltimore: No. Alesia - Carroll Co. Md. St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6-DATE OF BIRTH, August 16-, 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Mill Worker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, Christopher Markey.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rachel Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Fuller

(Address) 3704 Huntingdon Ave

15- Robert P. Harrison, M.D.

NOV 24 1920 Burial Permit Issued. Registrar.

Dr. Morrison 3652 Roland Ave

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23-, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull

Accidental

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.
(Coroner.)

Nov 24 1920 (Address) 3622 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Alesia - Carroll Co. Md.	Nov. 25, 1920
20-UNDERTAKER William Cook	ADDRESS 502 S. Hall Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48355 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48355

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3234 Edmondell St.: 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Betzold

(a) RESIDENCE. No. 3234 Edmondell St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	-	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Track 073

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer P. R. R. Co Baltimore

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wm Betzold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gehring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry L Betzold

(Address) 3502 Hudson St

15 Filed NOV 2 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 19 20, to ....., 19....., that I last saw h.. alive on Nov 23 19 20 and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Leo Kaplinsky, M. D.

19 (Address) 3035 Edmondell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 26 1920

20 UNDERTAKER ADDRESS

W. F. Cook 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spez.—8-24-14—M. & T.—2000 Blks.

D.48356 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48356

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Guilford Manor, University Parkway ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Thurston

(Residence in Baltimore: No. Guilford Manor St.; 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Sept. 20, 1860 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
60 yrs. 2 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shipping clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John Thurston

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Julius Thurston

(Address) Guilford manor

15- NOV 24 1920 Robert P. Harrison, Registrar.
Filed ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920, to Nov. 24 1920, that I saw him alive on Nov. 23 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Heart disease (Mitral regurgitation)

(Duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Grip

(Duration) yrs. mos. 5 ds.

(Signed) L. F. Thurwell M. D.

Nov. 27, 1920 (Address) 2226 Madison ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	Nov. 27, 1920
20-UNDERTAKER William Cook	ADDRESS 502 E Hatt ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—(-9-19—H. P. Co.—1000 Blks.

D48357 HEALTH DEPARTMENT—CITY OF BALTIMORE D48357

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2419 Hudson pl ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavia Yates (called Mrs Harold Yates)

(a) RESIDENCE. No. 2419 Hudson pl ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jackson Yates

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Edward Co Va

PARENTS

10 NAME OF FATHER Lenard Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jackson Yates

(Address) 2419 Hudson pl

15 Filed NOV 25 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/26, 1920, to 11/23, 1920, that I last saw her alive on 11/22nd, 1920, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency following Influenza Pneumonia

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Diag

(Signed) Geo L Wells M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Nov 25 1920
20 UNDERTAKER	ADDRESS
D. A. Harvey	2314 Druid

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1048358 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048358

CERTIFICATE OF DEATH. 420

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 W. Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Jones

(Residence in Baltimore: No. 1633 W. Bruce St.; 12 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Married

6-DATE OF BIRTH, July 11th, 1891 (Month) (Day) (Year)

7-AGE, 29 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur 186
(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile Store

9-BIRTHPLACE, (State or Country), Long Green Balto Co Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Long Green Balto Co

12-MAIDEN NAME OF MOTHER Catherine Jones

13-BIRTHPLACE OF MOTHER (State or Country), Long Green Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Sullivan

(Address) 1633 W. Bruce St.

15- Filed NOV 25 1920 191... ROBERT B KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22nd, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1920, to Nov 22nd 1920, that I saw h[illegible] alive on Nov 22nd 1920, and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 6 yrs. — mos. ds.

(Signed) William Sullivan M. D.

11-23, 1920 (Address) 1706 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Long Green Balto Co DATE OF BURIAL, Nov. 25, 1920

20-UNDERTAKER Edw. Ringgold ADDRESS 1463 N. Carey St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48359 HEALTH DEPARTMENT—CITY OF BALTIMORE D48359

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adele Williams

(a) RESIDENCE. No. 1327 N. Vincent ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31(?)				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——?

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown.

(c) Name of employer 087

9 BIRTHPLACE (city or town) (State or country) ? Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Citz Hospital Records.
(Address)

15 NOV 25 1920 ROBERT E KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1920, to Nov 22, 1920, that I last saw her alive on Nov 22, 1920, and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Serological & clinical tests

(Signed) E. C. Medairy, M. D.

, 19 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Mt Auburn~~ St. Peters	Nov. 25 1920
20 UNDERTAKER Edw. Ringgold	ADDRESS 1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48360

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 566 Walnut alley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther Moore -

(Residence in Baltimore: No. 566 Walnut alley - St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, July (Month) 29 (Day), 1918 (Year)

7-AGE, 2 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Annie Moore

13-BIRTHPLACE OF MOTHER (State or Country), Maryland -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Queen

(Address) 566 Walnut Alley

15- NOV 25 1920 191... ROBERT B. KRAUTZ Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 01 1920, to Nov 23 1920, that I saw him alive on Nov 23 1920, and that death occurred, on the date stated above, at 12 20 a. m.

The CAUSE OF DEATH* was as follows:

Nov

Bronchial Pneumonia

(Duration).....yrs.....mos..3..ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration).....yrs.....mos..11..ds.

(Signed) Samuel A Bain M. D.

Nov 23 1920 (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Cem	Nov 24 1920.
20-UNDERTAKER Daniel Easton	ADDRESS 710 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mar V 2078

Spec.—6-9-19—H. P. Co.—1000 Bks.

L048361 HEALTH DEPARTMENT—CITY OF BALTIMORE L048361

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH REGISTERED NO.....

CITY OF BALTIMORE: (No. 14 S. Washington St., ST.; V 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Frances Pertner

(a) RESIDENCE. NO. 14 S. Washington ST., V WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow of Augustus Pertner

6 DATE OF BIRTH (month, day, and year) Dec. 24-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Whitebrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George A. Stein
(Address) 2037 E. Fountain St.

15 NOV 25 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1920, to Nov. 23, 1920, that I last saw her alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows: MBN

Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. A. Kirkpatrick M. D.

Nov. 24 1920 (Address) 1531 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Nov. 26 1920
20 UNDERTAKER Lilly and Zeller.	ADDRESS 400 S. Mt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic myocarditis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048362 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048362

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N. Chapel St.; 6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Freitag

(a) RESIDENCE. No. 116 N. Chapel St., 6 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Freitag

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Bibel

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Anna Freitag
(Address) 116 N. Chapel St.

15 Filed ..... 19 ..... ROBERT P. KRAUTER Registrar

NOV 25 1920 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/20 19

17 I HEREBY CERTIFY, That I attended deceased from 11/24/20, 19..., to 11/24/20, 19...,
that I last saw him alive on 11/23/20, 19...,
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows: 000

Acute Cellulitis of Scalp

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/22/20

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederick Wiseman M. D.

11/25/20 (Address) 2919 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 26 1920
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 E. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cellulitis from skin over mastoid.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1448363. 1537 2048363.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Weinstein

(a) RESIDENCE. NO. 1800 N. Smallwood St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: 45 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Record (Address): Johns Hopkins Hosp.

Filed NOV 25 1920 ROBERT R. KRAUTER Registrar Bristol Parish Olass

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23rd 1920 to Nov 24th 1920, that I last saw him alive on Nov 24th 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism
~~Aneurysm of the aorta~~

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary): Aneurysm of the aorta (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry M. Thomas Jr., M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 11/25 1920

20 UNDERTAKER: Jack Lewis — ADDRESS: 17 N Scott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic

Spec.—5-19-13—M. & T.—500 Bks.

D48364 HEALTH DEPARTMENT—CITY OF BALTIMORE D48364

CERTIFICATE OF DEATH. 109

1-PLACE OF DEATH Bressler Johnson Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2724 N Charles ST.; 18 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Freeman

(Residence in Baltimore: No. 401 N Schroeder St.; 8 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 15, 1912 (Month) (Day) (Year)

7-AGE, 8 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry H. Freeman

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Ida E Hepfel

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry H. Freeman

(Address) 401 N Schroeder St

15 NOV 25 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1920, to Nov 22 1920, that I saw h[illegible] alive on Nov 22 1920, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Obstruction of Intestines

..... (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Constipation

..... (Duration) yrs. mos. 1 ds.

(Signed) Dr. L. F. Kelly M. D.

11/22, 1920 (Address) 2042 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 8 yrs. mos. ds.

Where was disease contracted, if not at place of death? 401 N Schroeder St

Former or usual residence 401 N Schroeder St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 11/25, 1920

20-UNDERTAKER Engel Finley Sutton & Sayler ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2948365 HEALTH DEPARTMENT—CITY OF BALTIMORE 2948365

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 606 n Dallas St. WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Matthews

(Residence in Baltimore: No. 606 n Dallas St.; yrs., mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col.	Widow

6-DATE OF BIRTH, ...Sept....., 1..... (Month) (Day) (Year)

7-AGE, ...yrs.....mos. 27 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Matthews

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Anne Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Lippley

(Address) 606 n Dallas St

NOV 25 1920 Filed..... 191..... ROBERT B KRAUTER Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

11-27-1920 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Nov 25, 1920

20-UNDERTAKER R E Ross — ADDRESS 1405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48366 HEALTH DEPARTMENT—CITY OF BALTIMORE D48366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1912 Edmondson Ave. 16 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi Marshall Elder

(Residence in Baltimore: No. 1912 Edmondson Ave (If LESS than 1 year, yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, December 13, 1920
(Month) (Day) (Year)

7-AGE, 73 yrs. 11 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Retired) Supervisor of Short
(b) General nature of industry, business, or establishment in which employed (or employer) Line R. R.

9-BIRTHPLACE. (State or Country).
Sykesville, Md.

PARENTS.

10-NAME OF FATHER. Levi M. Elder

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Cordilia Brown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eliza Jane Elder

(Address) 1912 Edmondson Ave.

15-

NOV 25 1920 191.. ROBERT J. KRAUTER
Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

Nov. 24, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov. 25, 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148367 HEALTH DEPARTMENT—CITY OF BALTIMORE 148367

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Georgetown Rd Morrell St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Hastenauer

(a) RESIDENCE. No. Georgetown Rd Morrell St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Eva Hastenauer

6 DATE OF BIRTH (month, day, and year) Oct 19-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Hastenauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Teigel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Hastenauer (Address) Georgetown Rd Morrell St

15 Filed NOV 25 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1920, to Nov. 22, 1920, that I last saw him alive on Nov 22, 1920, and that death occurred, on the date stated above, at 2a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. ? mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine Examination + Clinical

(Signed) Estelle Hemming M. D.

11/24 1920 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 24 1920
20 UNDERTAKER	ADDRESS
H B Keppert	2236 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lillian Wessel.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48368 HEALTH DEPARTMENT—CITY OF BALTIMORE D48368

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Wessel

(a) RESIDENCE. No. 32nd. & Elm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis C. Wessel

6 DATE OF BIRTH (month, day, and year) July 9th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dr. Dietrich Asmen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elma Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis Wessel (Address) Roland Park

15 FILED NOV 25 1920 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/13 1920, to 11/23 1920, that I last saw h alive on 11/23 1920, and that death occurred, on the date stated above, at 7.35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds. 0720

CONTRIBUTORY (Secondary) Phlegmon

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma A. Ridgely, M. D.

11/25 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Nov 26 1920

20 UNDERTAKER F. A. Deane & Son

ADDRESS 703 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not puerperal

Barber

D48369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48369

CERTIFICATE OF DEATH.

REGISTERED No. C 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2177 E Lombard St.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen R Barber

(Residence in Baltimore: No. 2177 E Lombard St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH ..... Dec 28, 1884
(Month) (Day) (Year)

7-AGE, 36 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Pub Schools

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, John T Barber

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER, Margaret M Hawley

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T Barber

(Address) 2177 E Lombard St

15- Filed NOV 25 1920 ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ulrich M. D.
(Coroner)
11/25, 1920 (Address) 1500 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Nov 26, 1920

20-UNDERTAKER H Allen Fuller

ADDRESS 3517 Springdale Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

2048370 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048370

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3634 Elm av St., 13 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E. Connolly

(Residence in Baltimore: No. 3634 Elm av St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct 2nd 1899
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 7 mos. 21 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Croft

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rosa Sifle

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Connolly

(Address) 3634 Elm av

15- Filed NOV 25 1920 ROBERT B KRAUTER ..... 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21st 1920, to Nov 23 1920, that I saw h[illegible] alive on Nov 23 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov 23, 1920 (Address) 3843 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Sydney Chapel Cemetery	Nov 24, 1920
20-UNDERTAKER	ADDRESS
Horace Runge & Son	1631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D48371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48371

CERTIFICATE OF DEATH.

87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST.; 26 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bathenia Butler

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hosp. Records.
(Address)

15 Filed NOV 25 1920 ROBERT B KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920, to Nov 24, 1920, that I last saw her alive on Nov 23, 1920, and that death occurred, on the date stated above, at 5 1209 m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (general)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical data

(Signed) G. C. Medairy, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sherwood Cem. (Rockville)	Nov 26 1920
20 UNDERTAKER	ADDRESS
Horace Bunger Hon	3601 Fallsd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1048372 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048372

CERTIFICATE OF DEATH.

159

1-PLACE OF DEATH Pronounced Dead at REGISTERED NO. C.....

CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry T. Anderson

(Residence in Baltimore: No. Cecil Apartments Entaw & Dolphin St.; (yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, March 17, 1868 (Month) (Day) (Year)

7-AGE, 52 yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 945

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward anderson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sallie Tydings

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maude anderson

(Address) Cecil Apartments

15- Filed NOV 25 1920 191... ROBERT P. KRAUSE Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
neck Self Inflicted
Suicide

(Duration).....yrs.....mos. 4 hrs. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration).....yrs.....mos. 4 hrs. ds.

(Signed) James H. Fenton M. D. (Coroner.)

Nov. 25 1920 (Address) 701 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Cecil Apartments

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Nov. 26, 1920
20-UNDERTAKER, W J Eckner Sons	ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0948373 HEALTH DEPARTMENT—CITY OF BALTIMORE 0948373

CERTIFICATE OF DEATH. 92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4718 Park Heights Ave ST.: 27 WARD)

2-FULL NAME J. Arthur L Newman

(a) RESIDENCE: No. 4718 Park Heights ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida G. Newman.

6 DATE OF BIRTH (month, day, and year) July 9 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Katherine Angel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Ida G Newman (Address) 4718 Park Heights

15 NOV 25 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 23, 1920, that I last saw h alive on Nov 26, 1920, and that death occurred, on the date stated above, at 4 00 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) Cyanosis

(duration) ...yrs ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) S. M. Lumpkin, M. D.

Nov 27, 1920 Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 26 1920
20 UNDERTAKER W Fletcher & Son	ADDRESS Walbert

mation should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

E should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPA- s on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

48374 HEALTH DEPARTMENT—CITY OF BALTIMORE 48374

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1340 Charles St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob E. Halfenstein

(Residence in Baltimore: No. 1727 N. Charles St.; 25 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 24 (Month), ... (Day), 1870 (Year)

7-AGE. 50 yrs. 6 mos. ... ds. — If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Contractor

9-BIRTHPLACE, (State or Country) Martinsburg W. Va.

PARENTS.

10-NAME OF FATHER, Halfenstein

11-BIRTHPLACE OF FATHER (State or Country) Martinsburg, W. Va.

12-MAIDEN NAME OF MOTHER Mylard

13-BIRTHPLACE OF MOTHER (State or Country) Martinsburg W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Halfenstein

(Address) 1727 N. Charles

15- Filed NOV 26 1920 ROBERT B KRAUTER Registrar of Vital Statistics

N. B.—Entries of information should be carefully supplied. Exact statement of OCCUPATION is very important. See that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1920, to Nov. 24 1920, that I saw h[illegible] alive on Nov. 24 1920, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Sub-acute Pancreatitis

(Duration) ... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ... yrs. ... mos. 5 ds.

(Signed) [illegible] M. D.

Nov 24, 1920 (Address) 1340 St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 1 mos. — ds. In the State 25 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va. — DATE OF BURIAL, Nov 26, 1920

20-UNDERTAKER [illegible] — ADDRESS 1429 E. Oak

Spec.--6-9-19--H. P. Co.--1000 Bks.

48375 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-02 48375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH So. Balto. Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Tillie Nagel

(a) RESIDENCE. NO. 1532 Boyle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Wm Nagel

6 DATE OF BIRTH (month, day, and year) July 5 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER — Krofoki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany Lithuania

14 Informant (Address) Jno. W. Nagel. 1532 Boyle St.

Date NOV 26 1920 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/20 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1920, to Nov. 24, 1920, that I last saw her alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia Streptococcic,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia 5 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Nov.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Ponte Jr., M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	11/27 19

20 UNDERTAKER Wm J. Erdman & Son ADDRESS 1928 Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948376 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948376

CERTIFICATE OF DEATH. 92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 S'harp ST.: 23 WARD)

2-FULL NAME Leonard Chester

(a) RESIDENCE. No. 926 Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elsie Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elsie Chester (Address) 924 Sharp St

15 Filed NOV 26 1920, 19 ROBERT F. [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18 1920, to Nov 24, 1920, that I last saw him alive on Nov 23, 1920, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) As Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 926 S Sharp St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) [illegible], M. D.

(Address) 712 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 26 1920
20 UNDERTAKER John H Goodman	ADDRESS 142 Argyle St

MARGIN

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048377 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048377

CERTIFICATE OF DEATH. X41

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sadie E. Black

(a) RESIDENCE. NO. Reisterstown Md ST., WARD. Carroll Co Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. H. Black

6 DATE OF BIRTH (month, day, and year) Sept 17 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Moses Stanbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Elizabeth Shiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Wm H. Black

(Address) Reisterstown Md

15 NOV 26 1920 ROBERT B KRAUTER. Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 24, 1920, that I last saw her alive on Nov 24, 1920, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) ? yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Subacute Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 11/20/20

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Le Leilbur Stewart, M. D.

11/24 1920 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Evangelical Lutheran Church — DATE OF BURIAL Nov 28 1920

20 UNDERTAKER Geo W Little — ADDRESS 531 St Fremont a

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048378 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 E. Chase ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lutz

(a) RESIDENCE. No. 1007 N. Bond ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 87 yrs. mos. 9 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Lutz

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
87		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER Christian Most

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eichman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Lutz (Address) 1007 N. Bond st

15 Date NOV 26 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1920, to Nov. 23. 1920, that I last saw her alive on " " 1920, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) George A. Hartmann, M. D.

Nov. 25 1920 (Address) 3214 Maryfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 26 1920

20 UNDERTAKER Phillip Joerdens

ADDRESS 2174 E. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

048379 HEALTH DEPARTMENT—CITY OF BALTIMORE 048379

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loeb Levin

(Residence in Baltimore: No. Hebrew asylum St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Unknown (Month) (Day) 1845 (Year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sol Levin

(Address) 1044 N. Eden st

15-

Filed NOV 28 1920 ROBERT B. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24th. 1920, to Nov. 25th, 1920, that I saw him alive on Nov. 25th, 1920, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. Sanders M. D.

Nov. 25th, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hebrew Asylum

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cemt — DATE OF BURIAL, Nov. 26, 1920.

20-UNDERTAKER Sol Levinson — ADDRESS 1919 Madison Ave

N.B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Sept 1948380

1948380 HEALTH DEPARTMENT—CITY OF BALTIMORE Md. Co

CERTIFICATE OF DEATH. 50 243 2nd St

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3647 Chestnut ST. 13 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Etta Allen

(a) RESIDENCE. No. 3647 Chestnut ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Allen

6 DATE OF BIRTH (month, day, and year) March 6 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) God

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Calvin Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Martha Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant W S Allen
(Address) 3647 Chestnut Ave

15 Filed NOV 25 1920 Registrar ROBERT E KRAUSER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17

I HEREBY CERTIFY, That I attended deceased from July, 1918, to Nov. 20, 1920, that I last saw her alive on Nov. 23, 1920, and that death occurred, on the date stated above, at 12. 30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

Duration 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Laboratory

(Signed) Thos M Statler M.D.

11/26 1920 (Address) 243 S Mary land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hamden	Nov 26 1920
20 UNDERTAKER H Mc Cook	ADDRESS St & 10th

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048381

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048381

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. McCleary

(a) RESIDENCE. No. 633 Wyatt Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Distributor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James McCleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Kroneg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed NOV 26 1920 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1920, to November 24 1920, that I last saw h im alive on November 24, 1920, and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face.

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? not as yet. What test confirmed diagnosis? Micro. Section

(Signed) J. G. Holden, M. D.

11/24/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Civic Cemetery — DATE OF BURIAL Nov 27 1920

20 UNDERTAKER Medlian Cook — ADDRESS Fort & Nash

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D48382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48382

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 E 35th St. St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth Warfield

(Residence in Baltimore: No. 501 E 35th St. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, February 8th (Month) (Day), 1846 (Year)

7-AGE, 74 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Bitzhalor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susanna Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Huth

(Address) 501 E. 35th Street

15-

Filed NOV 26 1920, 191.... ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23rd (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23rd 1920, to Nov 23rd 1920, that I saw h-r alive on Nov 23rd 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 4 yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Nov 23rd 1920 (Address) 401 E 35th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Nov. 24, 1920

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Visiel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48383

50

948383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1135 Valley ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha M. Gizriel

(a) RESIDENCE. No. 1135 Valley St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 ~~Single, Married,~~ Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Gizriel Sr

6 DATE OF BIRTH (month, day, and year) July 22 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER John Cornelius

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md.

12 MAIDEN NAME OF MOTHER Precilla Parks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Wm. Gizriel Sr.
(Address) 1135 Valley St.

15 Filed NOV 26 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1920, to Nov. 24th, 1920, that I last saw h.v alive on Nov. 24th 12 M, 1920, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes,

(duration) 7 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchitis with Diabetic Coma (duration) 3 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Microscopical

(Signed) Wilmer Brinton M. D.

, 19 (Address) S. W. Cor. Calvert & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. — DATE OF BURIAL: Nov 29 1920

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. North Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

St-ec.—6-9-19—H. P. Co.—1000 Blks.

1048384

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048384

CERTIFICATE OF DEATH.

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 - East 25th St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank E. H. Koch

a) RESIDENCE. No. 346 - E. 25th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1903

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	17	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 666

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William G. Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Ana M. Botzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): William G. Koch 346 E. 25th Street

15 Filed NOV 28 1920, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 20, to Nov 24, 20, that I last saw him alive on Nov 23 20 and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 20 (Address) 100 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Nov 27 1920

20 UNDERTAKER: William Cook — ADDRESS: 504 E. North Ave.

be stated EXACTLY. PHYSICIANS should be
y be properly classified. Exact statement of OCCUPA-
k of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—8-24-14—M. & T.—2000 Blks.

1048385 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048385

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N. Bond St. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lisa Weinstein

(Residence in Baltimore: No. 626 N. Bond St. St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, Unknown (Month), (Day) 1 (Year)

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): (NONE)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unkown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russia

(Address) 1411 E. Balto St

NOV 26 1920

Filed ....., 191... ROBERT L. [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 1920, to Nov. 25 1920, that I saw her alive on Nov. 25 1920, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows: Fracture of head of left femur followed by hypostatic Pneumonia (3 days) ovw

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) Israel K. Singer M. D.

Nov. 26, 1920 (Address) 200 1/2 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Int Carmel	11-28-20, 191
20-UNDERTAKER Jack Levin	ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0648386 HEALTH DEPARTMENT—CITY OF BALTIMORE. 0648386

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1142 Columbia Ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick English

(a) RESIDENCE. NO. 1142 Columbia Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced
HUSBAND of — (or) WIFE of Margaret English.

6 DATE OF BIRTH (month, day, and year) Unknown 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter 075

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick English.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Wm. English. (Address) 1142 Columbia Ave.

15 FILED NOV 26 1920 ROBERT I. FEASTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1920, to Nov 24, 1920, that I last saw h[illegible] alive on Nov 22, 1920, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

Nov 26 1920 (Address) 624 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Nov. 29th 1920
20 UNDERTAKER	ADDRESS
J. J. Govan & Son	901 Hollins

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Attention is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1048387 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1609 Jackson St. ST.: 24 WARD) 29 REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lavinia E. Benjamin.

(Residence in Baltimore: No. 1609 Jackson St. St.; 60 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, May 2nd. 1860, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
60 yrs. 6 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Hugh Hardy.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Louisa Hamilton.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgia McCann (daughter)

(Address) Boonsboro Md.

15- Filed NOV 26 1920 191.... ROBERT F KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23rd. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Harry E. Barnhardt M. D.
(Coroner.)

Nov. 25..., 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
WESTERN	NOV 26 1920 19....

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048388 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048388

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633½ N. Bowker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Coates

(a) RESIDENCE. No. 633½ N. Bowker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Virginia

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant pol

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Chas Gassaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Chas Gassaway

(Address) 633 N. Bowker St.

15 NOV 26 1920 ROBERT J. SLATTERY Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 25/Nov 1920

17 I HEREBY CERTIFY, That I attended deceased from 24/Nov., 1920, to 25/Nov, 1920 that I last saw him alive on 25/Nov, 1920 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam.

(Signed) Charles J. Baggott, M. D.

, 19 (Address) 1207 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Ethos	Nov 27th 1920

20 UNDERTAKER Earnest E. Wright ADDRESS 1364 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48389 Harryman 1920 T 33 66 D48389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 Whitridge Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice V. Harryman

(Residence in Baltimore: No. 435 Whitridge Ave St.; 77 yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	single

6-DATE OF BIRTH. Oct (Month) 17 (Day), 1843 (Year)

7-AGE. 77 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, David Harryman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Alice Stratton

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Poole

(Address) 435 Whitridge Ave

15- NOV 26 1920 Filed....., 191.... ROBERT E KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1920, to Nov 24 1920, that I saw her alive on Aug 24 1920, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) E. H. Duncan M. D.

Nov 24, 1920. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Nov 26, 1920

20-UNDERTAKER W. H. Sweeting ADDRESS 624 N Eutaw

Regd Dec 1920 mw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Paserskis ✓

D48390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48390

CERTIFICATE OF DEATH.

1082

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ursula Paserbsky

(a) RESIDENCE. No. 529 W. Barre ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~ or Divorced (write the word): Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1887

7 AGE — Years: 33 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoress 69

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Mike Paserskis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Mary Kuntemates

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Katherine Paserskis

(Address) 1203 Park St.

Nov 26 1920

ROBERT E. LEACH, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1920, to Nov. 24, 1920, that I last saw h.. alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Appendix Operation Date of Oct 23

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) ..... M. D.

11-24-1920 (Address) St Joseph's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 27 1920
20 UNDERTAKER	ADDRESS
Cahn Lithuanians	1203 Park

mation should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec. 6-9-19—H. P. Co.—1000 Bks.

D48391 HEALTH DEPARTMENT—CITY OF BALTIMORE D48391

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 N. East Ave ST. 76 WARD)

2-FULL NAME Albrecht Sander

(a) RESIDENCE. No. 335 N. East Ave ST. 17 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie C. Sander

6 DATE OF BIRTH (month, day, and year) Apr 13-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) Brewery

(c) Name of employer G. B. S. Brewery

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Albrecht Sander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie C. Sander

(Address) 335 N. East ave

15 Filed NOV 26 1920 Robert L. Knott Registrar

Burial Permit Ot...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23 Nov 1920

17 I HEREBY CERTIFY, That I attended deceased from 21 Nov 1920, to 23 Nov 1920, that I last saw h.im alive on 23 Nov 1920, and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam by

(Signed) Dr. Smoke, M. D.

, 19 (Address) 301 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 26 1920
20 UNDERTAKER	ADDRESS
F. C. Trane & Son	763 Hanover St

Station should be careful, supplied. ALL should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

248392 — 248392

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Johnson.

(Residence in Baltimore: No. 1403 Bruce St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH: ....., 1865
(Month) (Day) (Year)

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Prestman St.

15-

Filed ..... 191.....
Registrar.

NOV 26 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1920, to Nov 26 1920, that I saw h[illegible] alive on Nov 25 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 1 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles L. Clark M. D.

Nov 25 1920, (Address) 1306 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Nov. 27., 1920.

20-UNDERTAKER — ADDRESS

JAMES H. DENNIS
1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48393

CERTIFICATE OF DEATH.

120 D 48393

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707-W-Franklin ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williams Wicks.

(a) RESIDENCE. No. 1707-W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Negro	Married

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rose Wicks

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Concern

(c) Name of employer David Taylor

9 BIRTHPLACE (city or town) Howard Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ned Wicks

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Rose Wicks.
(Address) 1707-W-Franklin St

15 Filed NOV 26 1920 ROBERT B. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23, 19 20

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 19 20, to 11-23, 19 20, that I last saw h.. alive on 11-23, 19 20, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Stenosis

(duration) 1 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. ~~Pneumonia~~ Pneumonia uplobe

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical Signs

(Signed) Wally J. Peters, M. D.

, 19 (Address) 618-W-Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 26 19 20

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

mation should be carefully supplied. Exact statement is desired. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 48394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48394

CERTIFICATE OF DEATH.

REGISTERED No. C 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Rayner ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie B. Anthony

(Residence in Baltimore: No. 2504 Rayner ave. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, September (Month) 15 (Day), 1870 (Year)

7-AGE, 50 yrs. 2 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. house-wife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Aron Cunningham

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aron Anthony

(Address) 2504 Rayner ave.

15-

Filed NOV 26 1920 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 24 1920, to November 25 1920, that I saw h[illegible] alive on November 24 1920, and that death occurred, on the date stated above, at 6:55a m.

The CAUSE OF DEATH* was as follows:

S/W

Goitre

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) Chester Riland, M. D.

11-25, 1920. (Address) 2532 Edmondson ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL. Nov. 28, 1920

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1455 48395 — 1220 D 48395

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Griffin

(a) RESIDENCE. NO. 1136 Woodyear St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Saml. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Tomlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record J. H. H.
(Address)

15 Filed NOV 26 1920 ROBERT L. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1920, to Nov 24, 1920, that I last saw him alive on Nov 24, 1920, and that death occurred, on the date stated above, at 4 21 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis (?)
Cystitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none except urine exam.

(Signed) W. Bierman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mencek Whorp Va	Nov 26 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1363 PRESTMAN ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048396

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048396

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4609 Elsrode ave ST.: Gainsville WARD 7)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian G. Haase

(a) RESIDENCE. No. 4609 Elsrode ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Haase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna C Plagemeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miss anna Haase
(Address) 4609 Elsrode ave

15 Filed NOV 26 1920 ROBERT E KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 1918, to Nov 24 1920, that I last saw h alive on Nov 24 1920, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion +
Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Phthisis +
Tubercular Enteritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Summers, M. D.

11/24 1920 (Address) 4906 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 27th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048397

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048397

CERTIFICATE OF DEATH.

92-105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Ailsa ave ~~ST.~~ Lauraulf (WARD) 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Heck

(a) RESIDENCE. NO. 3 Ailsa ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 14th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Keilholtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Krabatter
(Address) No 3 Ailsa ave

15 Filed NOV 26 1920 ROBERT E. LEWIS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1920, to Nov 25, 1920, that I last saw h[illegible] alive on Nov 25, 1920, and that death occurred, on the date stated above, at 2.04 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John J. Heck M. D.

1920 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 29th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

MATION SHOULD BE CAREFULLY SUPPLIED. Exact statement of the facts required, so that it may be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

1048398

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048398

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Walker.

(a) RESIDENCE. No. 307 S. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 31 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Chas Walker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lottie Pearl Nov. 26 1920

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Lottie Walker
(Address) 307 S. Bruce St.

15 NOV 26 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1920, to Nov. 25, 1920, that I last saw him alive on Nov. 25, 1920, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

acute lymphatic leukaemia

(duration) — yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Tonsilitar diptheria

(duration) — yrs. — mos. 02 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood smears + Cultures.

(Signed) B Blackfordam M. D.

(Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Comty	Nov 27 1920

20 UNDERTAKER — ADDRESS

Wm. Miss Nr 8' [illegible]

mation should be carefully supplied. Any items CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48399

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Barclay ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Barren

(Residence in Baltimore: No. 1114 Barclay St St. Life 58 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1862 (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Bannon

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate C. Neill

(Address) 1114 Barclay St

15-

NOV 26 1920 Burial Permit Clerk.

Filed ....., 191.....

Robert F. Martson, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 1920, to Nov 23 1920, that I saw her alive on Nov 23 1920, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

1 .....

2 Pulmonary Tuberculosis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) 1 yrs. 8 mos. 8 ds.

(Signed) Luigi D. DeStefano M. D.

Nov 25 1920, (Address) 407 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral | DATE OF BURIAL, Nov 21, 1920

20-UNDERTAKER E. A. Mudgett Jr | ADDRESS 501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48400 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48490

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 W. 25th St. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret S. Howard

(a) RESIDENCE. NO. 132 W. 25th St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Howard Sr.

6 DATE OF BIRTH (month, day, and year) ? 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Carr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Hickey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Howard

(Address) 132 W 25th St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19th, 1920, to Nov. 26th, 1920, that I last saw her alive on Nov. 26th, 1920, and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Paraplegia

60 yrs

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Gross. M. D.

. 19 (Address) 2409 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen Md	Nov 27 '20
20 UNDERTAKER	ADDRESS
Ehrenwerth & Son	Chestnut St

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

D.48401

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.48401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Aisquith ST.; 9 WARD)

2-FULL NAME Ethel A Younker

(a) RESIDENCE. No. 1515 Aisquith ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Younker

6 DATE OF BIRTH (month, day, and year) Jan 8 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

037

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Harry McComas

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Ella Cook

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant Charles Younker
(Address) 1515 Aisquith St

15 Filed NOV 26 1920 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26- 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1920, to Nov 26, 1920, that I last saw h[illegible] alive on Nov 26, 1920, and that death occurred, on the date stated above, at 3½ a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Suffocation -

(duration) ..... yrs. ..... mos. 5 minutes

18 Where was disease contracted if not at place of death? Intubation at place of death - Induction

Did an operation precede death? Yes Date of Nov. 26 - 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Nov 26, 1920 (Address) 711 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 27 20

20 UNDERTAKER Chenowith & Son ADDRESS 1 W Chestnut St

Information should be carefully supplied. Avoid the use of OCCUPATIONAL terms. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48402 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48402

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Hollins St. St.: 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith.

(a) RESIDENCE. No. 1713 Hollins St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Smith

6 DATE OF BIRTH (month, day, and year) June 29 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	26	

8 OCCUPATION OF DECEASED Engineer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md State Hospital.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Hugh Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine McTague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

11 Informant Catherine J. Smith

(Address) 1713 Hollins St.

15 Filed NOV 26 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 25 1920

17 I HEREBY CERTIFY, That I attended deceased from November 23. 1920, to November 24. 1920, that I last saw h[illegible] alive on November 24. 1920, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage in brain

Had stroke within 4½ years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. Joh. Vassallis, M. D.

, 19 (Address) 525 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Nov 29" 1920
20 UNDERTAKER	ADDRESS 2336
Wm J. Hartwell.	W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48403

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 D.48403

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. St. Elizabeths Home ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Groome

(Residence in Baltimore: No. St. Elizabeth's Homes St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: negro

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: Consent of Exam ....., 1918
(Month) (Day) (Year)

7 AGE: 2 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Committed by Peter M Smith to St Elizabeths Home Aug 18th

PARENTS

10 NAME OF FATHER: Couldn't obtain

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 NOV 28 1920 Filed ....., 191.....

JOHNS Robert P. Harrison, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 24, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1920, to, Nov 22 1920, that I saw h— alive on Nov 22, 1920, and that death occurred, on the date stated above, at 9H m.

The CAUSE OF DEATH* was as follows:

Chronic Gastro-Enteritis

(Duration) ..... yrs. 8 mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J Ayd M D. M. D.

Nov 24, 1920 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL ..... 191.....

20 UNDERTAKER: Robert P. Harrison, Registrar of Vital Statistics — ADDRESS NOV 21 1920

Mrs. Mrs. L. WOODALL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 48404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48404

CERTIFICATE OF DEATH.

X 41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Gontka

(a) RESIDENCE. NO. Cockeysville Rd ST., WARD. Black Rock Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? ? 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65 Years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belfast Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Carroll Euson
(Address) Bel Air Md

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

NOV 26 1920

Daniel Parrott Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Nov 25, 1920, that I last saw h[illegible] alive on Nov 25, 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestines

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 24 1920

Was there an autopsy? Clinical & Microscopic

What test confirmed diagnosis?

(Signed) Jno Griffith Dorsey M. D.

19 (Address) Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Black Rock Md	Nov 27 1920
20 UNDERTAKER	ADDRESS
W. C. Brookes	Sparks Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48405

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48405

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH 2034

CITY OF BALTIMORE: (No. ~~1420~~ Keyser St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Taylor

(a) RESIDENCE. No. Same ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 11/24/20

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ Gds

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Norman Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto (?)
(State or country) Md

12 MAIDEN NAME OF MOTHER Alberta

13 BIRTHPLACE OF MOTHER (city or town) Balto (?)
(State or country) Md.

14 Informant Dr. E. L. Stone
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 26 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1920, to 11/24, 1920,
that I last saw h[illegible] alive on 11/24, 1920,
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis
Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) E. L. Stone, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health,
Per. Wm. E. WOODALL.

NOV 26 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~44446~~
D. 48406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48406

CERTIFICATE OF DEATH.

61 X-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Carter

(a) RESIDENCE. NO. 2227 E. Monument St. City WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) House helper

(c) Name of employer Mrs. Levenson 2227 E Monument

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) Robert P. Harrison,

15 Filed NOV 26 1920, 19

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22nd, 1920, to Nov 23, 1920, that I last saw h in alive on Nov 23, 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis
(Meningococcus)

..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? + Culture -

(Signed) V. R. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 26 1920
20 UNDERTAKER Commissioner Health, Per Wm. E. WOODALL	ADDRESS

Pt. was unconscious when entered - No relations known

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of (illegible) TION is very important. See instructions on back of certificates.

358

Spec.—6-9-19—H. P. Co.—1000 Bks.

1446-29 D.48407

HEALTH DEPARTMENT—CITY OF BALTIMORE D.48407

CERTIFICATE OF DEATH. 61 X X V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E. Carey

(a) RESIDENCE. No. 90 Meridean Nashville Tenn WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Alexander Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Ethel Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Hospital Record
(Address) J H H

15 Filed NOV 26 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Nov 26 1920, that I last saw her alive on Nov 26 1920, and that death occurred, on the date stated above, at 4 00 a m.

The CAUSE OF DEATH* was as follows:

a Hydrocephalus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. Brooks, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nashville Tennessee	Nov. 26 19 20
20 UNDERTAKER	ADDRESS
H E Hughes	424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Epidemic Meningitis

Spec.—8-24-14—M. & T.—2000 Bks.

D.48408 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 92

CITY OF BALTIMORE: (No. 1512 Eutaw Place St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma McClelland Suter.

(Residence in Baltimore: No. 1512 Eutaw Place St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, January 2, 1852
(Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Carey McClelland

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Mary R. Green

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Suter Warfield

(Address) 1512 Eutaw Place

15-

Filed NOV 26 1920, 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1920, to Nov. 25 1920, that I saw her alive on Nov. 25 1920, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia.

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Heart disease

..... (Duration) 1 yr. ..... mos. ..... ds.

(Signed) John D. King M. D.

Nov. 26, 1920. (Address) 1425 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov 27 1920
20-UNDERTAKER	ADDRESS
Geo. H. Smith	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48409

91-084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. Stricker ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ball

(Residence in Baltimore: No. 421 N Stricker St.; 50 yrs. ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 6, 1831.
(Month) (Day) (Year)

7-AGE, 89 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Berkeley Co. West Virginia.

PARENTS.

10-NAME OF FATHER, Nicagha A Cooper

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Mary Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A. Ball

(Address) 421 N. Stricker St.

15-

Filed NOV 26 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Nov 25 1920, that I saw h.. alive on Nov 24 1920, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

..... (Duration).....yrs.....mos. 2 ds.

(Signed) J. M. Lampshire M. D.

Nov 25, 191.. (Address) 826 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 27, 191..

20-UNDERTAKER George J. Smith — ADDRESS 1005 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Marrotti

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48410 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48410

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1930 N Washington St.: 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenzo Marotti

(a) RESIDENCE. No. 1930 W Washington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary Cherigero

6 DATE OF BIRTH (month, day, and year) August 20 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Pension of City

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Lorenzo Marotti

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mary Marotti
(Address) 1930 W Washington St

15 Filed NOV 26 1920 19

Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1920, to Nov 25, 1920, that I last saw h alive on Nov 25, 1920, and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:

Uraemia Contributory

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Wenlock, M. D.

(Address) 422 Brady Nov. 26, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 27 1920
20 UNDERTAKER	ADDRESS
E J Deming & Son	1938 E Lafayette Ave.

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48411 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 48411

CERTIFICATE OF DEATH

120

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2543 Oak St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Reed

(Residence in Baltimore: No. 2543 Oak St. 20 yrs. ..... mos. ..... ds.)

B. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Col | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH ..... (Month) ..... (Day), 1865 (Year)

7 AGE: 55 yrs. ..... mos. ..... ds. | if LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Frank Reed

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Emily Reed

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily Reed

(Address) 2543 Oak St

15. NOV 27 1920, 191 Robert P. Harrison, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 25 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1920, to Nov. 25 1920

that I saw h[illegible] alive on Nov. 25, 1920.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Nephritis (Bright Disease) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Garland Schmidt M. D.

Nov 26, 1920 (Address) 1534-6 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem | DATE OF BURIAL: Nov 28 th, 1920.

20 UNDERTAKER: Joseph A. Farell | ADDRESS: 230 Division St East, Md.

D. 48 412 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48412

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 Whatcoat ST.: 15 WARD)

REGISTERED No. C

2-FULL NAME Charles F. Broadbent

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1311 N. Gilmor

Life

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, September 5, 1850
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: salesman
(b) General nature of industry, business, or establishment in which employed (or employer): (drugs) 066

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Stephen Broadbent

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary E. Scott

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felipps A. Broadbent

(Address) 2647 N. Charles St.

15- Robert P. Harrison,

Filed NOV 27 1920, 191.. Burial Permit Clerk Registrar.

N.B.—Every item of information should be carefully considered before answering. Remember that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 26, 1920. (Address) 2802 Eastfordham Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, 11/2..., 19..20

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—5-19-13—M. & T.—500 Bks.

D. 48413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48413

CERTIFICATE OF DEATH.

152

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bradley Tillman Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Henry Pryor Jr.

(Residence in Baltimore: No. 3407 Birch ave St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 22, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nursing
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James B. Pryor

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md

12-MAIDEN NAME OF MOTHER, Agnes E. Kennedy

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James B. Pryor

(Address) 3407 Linwood

15-

NOV 27 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to November 26 1920, that I saw him alive on November 26 1920, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Impressed from difficult instrumental delivery

..... (Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Helen F. Wiseman M. D.

Nov 26 1920 (Address) 1211 W. Lafayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 30, 1920
UNDERTAKER	ADDRESS
H. B. Buckmaster Sons	Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48414

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Louise Taylor

(Residence in Baltimore: No. 818 Pierce Pierce Street St.; 0 yrs., 0 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH, November (Month) 26 (Day), 1920 (Year).

7-AGE, 0 yrs. 0 mos. 7 ds. If LESS than 1 day, ~~hrs.~~ or ~~min.~~?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas George Taylor

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Maggie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Smith (Mother)

(Address) 818 Pierce Street

15-

Filed NOV 27 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 26 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from November 19 1920, to November 26 1920, that I saw her alive on November 25 1920, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Immaturity of Child

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Maternal Syphilis and Stillbirth

(Duration) 1 yrs. ? mos. ? ds.

(Signed) J. Morris Hall M. D.

Nov 26 1920. (Address) University Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 29, 1920.

20-UNDERTAKER Brown and Freeland — ADDRESS 1140 W. Lexington St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Name and Kind of Occupation Always important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48415 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1492

CITY OF BALTIMORE: (No. 737 W. North ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Kay Walker

(a) RESIDENCE. No. 737 W. North ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Edwin Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Kate B. Keyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joshua Walker
(Address) 737 W. North ave

15 Filed NOV 27 1920 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 1920, to Nov 25 1920, that I last saw h[illegible] alive on Nov 25 1920, and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Collapse
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Howard C Silver, M. D.

, 19 (Address) 1914 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Nov 27 1920
20 UNDERTAKER	ADDRESS
John O'Mitchell	120 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48416

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Brantley ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Seth Hopkins

(Residence in Baltimore: No. 1034 Brantley St.; 40 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 12 (Day), 1834 (Year)

7-AGE, 86 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, ~~Hilleary Hopkins~~

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hilleary Hopkins

(Address) Tacoma Park.

15- Filed NOV 27 1920, 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Nov. 25 1920, that I saw h alive on Nov 25 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTOR (Secondary) Enlarged Prostate age

(Duration) 4 yrs. mos. ds.

(Signed) John H Cain M. D.

Nov. 25, 1920 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Grove Cem, Aberdeen Md. DATE OF BURIAL, Nov 27, 1920

20-UNDERTAKER John O. Mitchell ADDRESS 120 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact name of disease, not mode of dying, is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48417

CERTIFICATE OF DEATH.

9-15

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Stinsky (STAVSKI)

(Residence in Baltimore: No. 713 N. Port St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	

6-DATE OF BIRTH, ... 8 (Month) ..... 30 (Day), 1919. (Year)

7-AGE, ... 1 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), America Md

PARENTS.

10-NAME OF FATHER, Frank Stavsky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Louisa Pohl

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Stavsky

(Address) 713 N. Port St.

15-

Filed ....., 191.... Robert P. Harrison,
NOV 27 1920 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-30 1920, to 11/25 1920, that I saw h er alive on 11/25 1920, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows: Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ..... ds.

CONTRIBUTORY (Secondary) Chronic Malnutrition

..... (Duration) 1 yrs. 1 mos. ..... ds.

(Signed) B. Sacks M. D.

11/25, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 27., 1920

20-UNDERTAKER Levi Levi & Son — ADDRESS 1166 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48418

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1809½ Penna Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank L Giese

(Residence in Baltimore: No. 1809½ Penna Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1845 (Year)

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchmaker
(b) General nature of Industry, business, or establishment in which employed (or employer): 139

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frank Giese

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Pentenreuther

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L Stein

(Address) 1809 Penna Ave

15- Robert P. Harrison,

Filed NOV 27 1920, 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Nov 25 1920, that I saw h[illegible] alive on Nov 25 1920, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Paralysis & Exhaustion

(Duration) 5 yrs. 3 mos. ds.

(Signed) Thos. H. Buchanan M. D.

Nov. 27, 1920 (Address) 1100 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Nov 28., 1920

20-UNDERTAKER Watkins Fisher & Sons

ADDRESS 821 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48419 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Segerer.

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	~~Single~~ Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER ? Segerer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address) City Hospital Bay View

15 Filed NOV 27 1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1920, to Nov. 24, 1920, that I last saw him alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage.)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tubercu-
losis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Usual test

(Signed) [illegible], M. D.

11-25, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Nov 29 1920
20 UNDERTAKER	ADDRESS
Lilly and Zile	403 Stru[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20.48420

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

20.48420

REGISTERED NO. C 6400

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3120 Greenmount Ave ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. Bonsall

(Residence in Baltimore: No. 3120 Greenmount Ave St.; Life ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOW, OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: November 12, 1847 (Month) (Day) (Year)

7-AGE: 73 yrs. - mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Andrew Huff.

11-BIRTHPLACE OF FATHER (State or country): Harford Co. Md.

12-MAIDEN NAME OF MOTHER: Elizabeth Lenham

13-BIRTHPLACE OF MOTHER (State or country): Harford Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence V. B. Bonsall.

(Address) 3120 Greenmount Ave.

15. NOV 27 1920 Robert P. Harrison, ... 191 ... Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 26 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1920, to Nov. 26 1920, that I saw h... alive on Nov. 25, 1920, and that death occurred, on the date stated above, at 5.0 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) — See above

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. G. Prentiss M. D.

Nov. 26, 1920 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Johns - Waverly.

DATE OF BURIAL: Nov. 28 - 1920

20-UNDERTAKER: William Cook.

ADDRESS: 502 E. North Ave.

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 48421 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48421

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE (No. in ambulance on way to Hospital 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace M. Walstore

(Residence in Baltimore: No. 3034 Stafford St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fractions of days should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1875. (Year)

7-AGE,	If LESS than 1 day,
43 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos McDonald

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Emily Dorman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myrtle Mayer

(Address) 3063 Stafford St

15- Robert P. Harrison,

Filed....., 191..... Registrar.

NOV 27 1920 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) dont know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any

(Duration) yrs. mos. ds.

(Signed) H B Forrest (Coroner.) M. D.

11-27, 1920 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mound Cem	Nov 29, 1920
20-UNDERTAKER Robert Anderson	ADDRESS 178 Calhoun St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48422 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48422

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 435 East 23 St.; 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Jeffries

(a) RESIDENCE. No. 435 East 23 St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Cl	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Jeffries

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 421

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford Co- Md

PARENTS

10 NAME OF FATHER Abner Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co- Md

12 MAIDEN NAME OF MOTHER Martha Whitington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Daniel Jeffries

(Address) 435- East 23rd St

15 Witness Robert P. Harrison,

NOV 27 1920

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1920, to Nov 24, 1920, that I last saw h[illegible] alive on Nov 24, 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

9 Months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 26. 1919

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Paul Chandler, M. D.

(Address) 1534- E. B. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fortestia Md	Nov 27 20
20 UNDERTAKER	ADDRESS 1726
Mrs Pool & Elliott	Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48423

144479 D. 48423

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 1600 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Blackwell.

(a) RESIDENCE. No. 1103 Mosher St. City. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Clay Blackwell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John Reeves (Address)

15 Filed NOV 27 1920 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov. 22, 1920, that I last saw him alive on Nov. 22, 1920, and that death occurred, on the date stated above, at 2.55 p. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta
Aortic Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Over)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. R. Mason M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cram Va	Nov 24 1920

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1302 PRESTMAN ST.

mation should be carefully supplied. Age should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,484424

20,484424 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4123 Falls Road ST.; 13 WARD)

2-FULL NAME Alpha M. Ruby

(a) RESIDENCE. No. 4123 Falls Road ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie A. Ruby

6 DATE OF BIRTH (month, day, and year) Dec. 5-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Alpha M. Ruby

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Snyder

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. (State or country) Md.

14

Informant Mrs. Susie A. Ruby

(Address) 4123 Falls Road

Filed NOV 27 1920 19... Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1920.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1919, to Nov. 25, 1920, that I last saw him alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank H. Machen, M. D.

19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov. 29 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 363 Hall Pl

mation should be carefully supplied. Any alone CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48425

Spec.—6-9-19—H. P. Co.—1600 Bks.

D. 48425 HEALTH DEPARTMENT—CITY OF BALTIMORE

32

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4010 Roland Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Essie D. Gladfelter

(a) RESIDENCE. No. 4010 Roland Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Gladfelter

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes V. Cooke

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or country) Md.

14 Informant Mrs. Agnes V. Cooke (Address) 4010 Roland Ave

15 Filed NOV 27 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Nov 25, 1920, that I last saw h[illegible] alive on Nov 23 + 8 pm, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

T. B. of Spine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Harrison, M. D.

Address 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Nov. 29 1920

20 UNDERTAKER Horace Burgee & Son — ADDRESS 1631 Falls Rd

Information should be Carefully Supplied. Avoid Abbreviations. Exact Statement of OCCUPATION should be properly classified. Exact information in regard to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information in regard to CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

948426 HEALTH DEPARTMENT—CITY OF BALTIMORE 948426

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2565 W Fairmount Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Rose. Engel.

(a) RESIDENCE. No. 2565 W Fairmount Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? X yrs. X mos. / ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	white.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 25 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, — hrs. or — min.
—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. F. Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie V. Carville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. F. Engel
(Address) 2565 W Fairmount Av

15 Filed NOV 27 1920, 19 Robert P. Garrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1920, to Nov. 26, 1920, that I last saw h[illegible] alive on Nov. 26, 1920, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Bron.
Acute 6 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. H. Cullen, M. D.

11/27/20 (Address) 2757 Wmont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 27 1920
20 UNDERTAKER	ADDRESS
H. B. Kephart	2236 Eutaw

NOTE.—WRITE PLAINLY; use pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY in YEARS, MONTHS, DAYS. CAUSE OF DEATH should state exact statement of OCCUPATION in plain terms, so that it may be properly classified. Read instructions on back of certificates. THIS SECTION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48427

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48427

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1517 N Spring ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LeRoy Heberlein

(Residence in Baltimore: No. 1517 N Spring St.; ....yrs.,....mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, November 3, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. mos. 23 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Christian Heberlein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Violet Hurst

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Heberlein

(Address) 1517 N. Spring St.

15- Robert F. Harrison, Registrar.

Nov 27 1920

Burial Permit C...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Nov 26 1920, that I saw him alive on Nov 26 1920, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Work!

Peritonitis "Probable appendicular Conditions" Acute Appendicitis Gangrenous

(Duration) ....yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. mos. 15 ds.

(Signed) P. H. Carman M. D.

Nov 26, 1920 (Address) 1702 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Nov. 29, 1920.

20-UNDERTAKER Richard F. Curley ADDRESS 206 Barclay St.

N. B.—Every item of information called for should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48428 HEALTH DEPARTMENT—CITY OF BALTIMORE D48428

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 811 Eastern ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Pietrocarlo

(a) RESIDENCE. No. 811 Eastern ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Infant

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS:

10 NAME OF FATHER: Lunardo Pietrocarlo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angelina Lunardo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Lunardo Pietrocarlo 811 Eastern ave

Filed NOV 27 1920 19 Record P. J. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from November 26 1920, to Nov 26, 1920, that I last saw h[illegible] alive on Nov 26, 1920, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Strangulated - cord
due to difficult Labor
and foetal Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

Nov 27 1920 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Nov 28 1920

20 UNDERTAKER: Kendall & Upperman — ADDRESS: 3 E. Lan[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48429

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 E. Lafayette Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel D. Heim

(a) RESIDENCE. No. 1234 Lafayette Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W. Fmle	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr Earnest Heim

6 DATE OF BIRTH (month, day, and year) Oct 7 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~House Work~~ ooo

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. Shrond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eliza Shrond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs I Shade 1234 Lafayette Ave

15 Filed NOV 27 1920, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1918, to Nov 24, 1920, that I last saw h[illegible] alive on Nov 23, 1920, and that death occurred, on the date stated above, at 3:35 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast
Acute ulcerative body
July 1918

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Epithelial Ulceration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emily C. Peterson M. D.

, 19 (Address) 432 E. York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 27 1920

20 UNDERTAKER Wendell Disposal Co ADDRESS 37 Penn St.

mation should be carefully supplied. AGE sho... stated EXACTLY in YEARS, MONTHS and DAYS. OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact [illegible]
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48430

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 703 Delphin St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Rupp

(a) RESIDENCE. NO. 703 Delphin St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Rupp

6 DATE OF BIRTH (month, day, and year) June 28 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 266

(b) General nature of industry, business, or establishment in which employed (or employer) Genl Mdse

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Minnie Rupp
(Address) 703 Delphin St.

15 Filed NOV 27 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1920, to Nov 25, 1920, that I last saw him alive on Nov 25, 1920, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

own
Tabes Dorsalis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paraplegia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) E. M. Lamprecht M. D.

(Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11-29-20
20 UNDERTAKER George A. Farley Fulton	ADDRESS & Fayette

mation should be carefully supplied. AGE, ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on b... ... of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—8-24-14—M. & T.—2000 Blks.

D.48431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48431

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Pierce ST.; 18 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Nelson

(Residence in Baltimore: No. 925 Pierce. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June (Month) (Day), 1870 (Year)

7-AGE, 50 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Evangelist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore Nelson

(Address) 925 Pierce St.

15-

Filed NOV 27 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Cle

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10th 1920. to Nov 24 1920.

that I saw h e alive on Nov 22nd 1920,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry T Brown M. D.

Nov 26, 1920. (Address) 1501 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Nov 25 1920.

20-UNDERTAKER Edward L Hawley ADDRESS 518 N Paca St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48432 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48432

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 754 Waseche ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Fisher

(Residence in Baltimore: No. 754 Waseche St., 52 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1868.
(Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Balto- Md

PARENTS.

10-NAME OF FATHER, Jeremiah Fisher

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Louisa Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cornelia Fisher

(Address) 754 Waseche St

15- Robert P. Harrison,

Filed NOV 27 1920, 191.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Nov 24 1920, that I saw him alive on Nov 23 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency ?

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. V ds.

(Signed) H R Hughes M. D.

11/26, 191.. (Address) 765 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Nov 27 20

20-UNDERTAKER A Daniel Stanley ADDRESS 5[illegible] W Biddle St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48433

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2704 Fairmount Ave St.; 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel B Buckley Jr

(Residence in Baltimore: No. 2704 Fairmount Ave St.; 39 yrs., 6 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, April 18, 1881. (Month) (Day) (Year)

7-AGE, 39 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) agent

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel B Buckley Sr

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Nolan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances R. Buckley

(Address) 8 W. Lombard St

15-

Filed ..... 191.....

NOV 27 1920

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 25, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to Nov 25 1920

that I saw him alive on Nov 25 1920

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

Contributory Bulbar Paralysis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

(Signed) Robert C Hatch M. D.

Nov 27, 1920. (Address) 2151 Sulgrave Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Nov 29, 1920

20-UNDERTAKER John J Gavan & Son

ADDRESS 901 Hollins

N. B.—Every item of information should be carefully considered, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48434 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48434

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 702 S Ann St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Berkowski

(Residence in Baltimore: No. 702 S Ann St St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1870 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Antoni Berkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalia Berkowski

(Address) 702 S Ann St

15-

Filed NOV 27 1920, 191.....

Robert. P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Lyn Smoller M. D.
(Coroner)

11/27, 1920. (Address) 1801 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Nov 29, 1920.
20-UNDERTAKER M. F. Sadowski	ADDRESS 705 S. Ann St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48435

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Wakeland

(a) RESIDENCE. No. 1813 Hanover ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Wakeland

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rachel Dail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edward Wakeland

(Address) 1813 Hanover St.

15 Filed NOV 27 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1919, to Nov 25, 1920, that I last saw h alive on Nov 25, 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell, M. D.

11/25/20 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	11/27 1920
20 UNDERTAKER	ADDRESS
John F. Fahey & Sons	W. 8 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY in every case. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48436

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 Rumsey ST. 24 WARD)

2-FULL NAME Geo. H. Coury

(a) RESIDENCE. No. 1134 Rumsey ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Coury

6 DATE OF BIRTH (month, day, and year) Jan. 3 — 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55		9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Home Lately

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER — Alex. Coury.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy md.

12 MAIDEN NAME OF MOTHER — Mary Pomucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Daughter (Mrs. Mary Troy) Father

(Address) — 1134 Rumsey Ave

Robert P. Harrison

15 Filed ..... 19 .....

NOV 27 1920

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1920, to Nov. 24 1920, that I last saw h[illegible] alive on Nov 24 1920, 2.00 P. m. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis duration 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. F. Wheeler, M. D.

Nov 25 1920 (Address) 1277 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	11/27 1920
20 UNDERTAKER John J. Lahey & Sons	ADDRESS 1318 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48437 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48437

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3218 E. Fairmount Av. ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Edwin D. & Matilda Walters Premature Birth

(a) RESIDENCE. NO. 3218 E. Fairmount Av ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 1 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Edwin D. Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Matilda Krebs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Edwin D. Walters
(Address) 3218 E. Fairmount Av.

15 Filed NOV 27 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 1.30 A. m.
The CAUSE OF DEATH* was as follows:)

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles S. Crook, M. D.

Nov. 1, 1920 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 27 1920
20 UNDERTAKER Lilly and Zeiler	ADDRESS 4038 Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48438

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apts ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer C. Hecht

(a) RESIDENCE. No. Riviera apts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Hecht

6 DATE OF BIRTH (month, day, and year) May 21-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept Store

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Samuel Hecht Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babett Wolfsheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Hecht

(Address) Riviera Apts

15 Filed NOV 27 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Nov. 26, 1920, that I last saw h[illegible] alive on Nov. 26, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvic Lymph Glands

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Embolism a few hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Microscopic

(Signed) Geo. L. Mitchell, M. D.

19 (Address) 6 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem	11/28 1920

20 UNDERTAKER David Sondheim ADDRESS 1826 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48439 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48439

CERTIFICATE OF DEATH.

151 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2 West Hamilton Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Asondale DeHoff Jr.

(a) RESIDENCE. No 2 West Hamilton Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Paul A. DeHoff

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Sandberg

13 BIRTHPLACE OF MOTHER (city or town) Knoxville (State or country) Tenn.

14 Informant Paul A. DeHoff (Address) 2 West Hamilton Ave.

15 Filed NOV 27 1920 [Burial Permit Clerk] Registrar

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 27, 1920, that I last saw him alive on Nov 26, 1920, and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (8 mos)

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Inanition (Artificial Feeding) (duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? Md. General Hospital

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical —

(Signed) John S. Fruby, M. D.

11/20, 1920 (Address) 3522 Greenmount ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 27 1920
20 UNDERTAKER	ADDRESS
Frank Lassahn & Son	Fulton Ave

Mation should be carefully supplied. AGE should be stated EXACTLY. PLACE OF BIRTH should be stated EXACTLY. NAME OF OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48440

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48440

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Vincent Ave ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Myers

(a) RESIDENCE. NO. 28 Vincent Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 45 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Emma Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Lucy A Myers

(Address) 1401 Dumas St

15 Filed NOV 27 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1920, to Nov 23, 1920, that I last saw him alive on Nov 23, 1920, and that death occurred, on the date stated above at 10:05 m.

The CAUSE OF DEATH* was as follows:

Uremic Cachexia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Frederick Md

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas Hellmuth M. D.

Nov 25 1920 (Address) 1504 Mc Culloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 27 1920
20 UNDERTAKER Charles Fisher & Sons	ADDRESS 1827 W. Balto St

NOV 27 1920

Should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. mation may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

48441 HEALTH DEPARTMENT—CITY OF BALTIMORE 48441

CERTIFICATE OF DEATH. X 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: — WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Frank Virdin

(a) RESIDENCE. No. 910 W. 4th St Wilmington Del. WARD. Wilmington Del
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margt. M. Virdin

6 DATE OF BIRTH (month, day, and year) Oct 13 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) — 054

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER James Virdin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Hospital Record (Address) Hosp

15 Filed NOV 28 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1920, to Nov. 27, 1920, that I last saw him alive on Nov 27, 1920, and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows: aortic stenosis

~~Heart failure~~

~~Mitral insufficiency~~

Myocardial insufficiency

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Wilmington, Del.

Did an operation precede death? N.D. Date of ...

Was there an autopsy? ~~No~~ yes

What test confirmed diagnosis? autopsy.

(Signed) C. R. Mason M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del	Nov 28 1920

20 UNDERTAKER John O Mitchell ADDRESS 1201 N Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

48442 HEALTH DEPARTMENT—CITY OF BALTIMORE 48442

CERTIFICATE OF DEATH. X 53

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: — WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. Samuel Cohen

(a) RESIDENCE. NO. Johns Hopkins Hospital ST., WARD. Emmitsburg Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)..... (State or country) Pa

PARENTS

10 NAME OF FATHER Mr. Davis Cohen

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant D. I. Cohen
(Address) Emmitsburg, Md.

15 Filed NOV 28 1920 19 ROBERT N. KRAUTER Registrar
Burial Permit 61971

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1920, to Nov. 27, 1920, that I last saw h ill alive on Nov 27, 1920, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia
acute exacerbation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Blood count + Smear

(Signed) Morris R. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md	11/27 1920

20 UNDERTAKER David Sondheim ADDRESS 11 W. Lexington St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48443

48443 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 39

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Walter

(a) RESIDENCE. NO. Pylesville, Md. ST., WARD. Pylesville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Waller

6 DATE OF BIRTH (month, day, and year) May 21 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) O&A

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pylesville - Md.

PARENTS

10 NAME OF FATHER Roberts Walters-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt L. Waller (Address) Pylesville Md

15 Filed NOV 22 1920, 19 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/23, 1920, to 11/27, 1920, that I last saw h l M alive on 11/27-, 1920, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Superior Maxillae

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Anaemia - Exhaustion

(duration) yrs. mos. 35 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11/27/20

Was there an autopsy? No-

What test confirmed diagnosis? Laboratory-

(Signed) E. S. Coster, M. D.

11/27, 1920 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pylesville Md.	Nov. 28 20
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048444

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048444

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 Pennington Ave ST. 25 WARD)
Curtis Bay

2-FULL NAME John Walter Kirby, Jr.

(a) RESIDENCE NO. 733 Pennington Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	7	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay, Md
(State or country)

PARENTS

10 NAME OF FATHER John Frederick Kirby

11 BIRTHPLACE OF FATHER (city or town) Brooklyn
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth K. Chernock

13 BIRTHPLACE OF MOTHER (city or town) Curtis
(State or country)

14 Informant John F. Kirby
(Address) 733, Pennington Ave.

15 Filed NOV 28 1920 ROBERT B KRAUSER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1920, to Nov. 27, 1920, that I last saw him alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis only

(Signed) Geo. E. Davis, M. D.

(Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Nov 28 1920
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and address should be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

D48445 HEALTH DEPARTMENT—CITY OF BALTIMORE D48445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH LOLA M. WADE

CITY OF BALTIMORE: (No. 200 Homewood ST.; 9 WARD)

REGISTERED NO. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola M. Wade

(Residence in Baltimore: No. 200 Homewood ave St. 1/2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 13 (Day), 1895 (Year)

7-AGE, 25 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)..... [illegible]

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles E. Wade

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catherine Youngman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Wade

(Address) 200 Homewood

15-

Filed NOV 28 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1915, to Nov. 25 1920, that I saw h... alive on Nov 25 1920, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. + mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry [illegible] M. D.

Nov. 27, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 29, 1920

20-UNDERTAKER E A Mudge Jr — ADDRESS 501 E 22 St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If under one day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

648446 HEALTH DEPARTMENT—CITY OF BALTIMORE 48446

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3144 Leeds St ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bowie

(a) RESIDENCE. No. 3144 Leeds ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vernon Bowie

6 DATE OF BIRTH (month, day, and year) Aug 22- 61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Vernon Bowie

(Address) 3144 Leeds St

15 NOV 28 1920 ROBERT I. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Nov 25-, 1920, that I last saw her alive on Nov 25- 1920 and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Friel, M. D.

11/26, 1920 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Penn	Nov 28 1920
20 UNDERTAKER	ADDRESS
Sam't H. Carol Son	1405 Mosher

...AGE should be stated EXACTLY. PHYSICIANS should be careful...mation should be carefully supplied. ...so that it may be properly classified. Exact statement of ...CAUSE OF DEATH in plain terms, so that ...ctions on back of certificates. ...TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048447 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048447

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1510 Rice (ST.:) 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Smith

(a) RESIDENCE. No. 1510 Rice ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Smith.

6 DATE OF BIRTH (month, day, and year) 6-13-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robt D Smith (Address) 1510 Rice

15 NOV 28 1920 ROBERT E KRAUSE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1920, to Nov 26, 1920

that I last saw h alive on Nov 26, 1920

and that death occurred, on the date stated above, at 10.20 A.m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis (duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Myocardidis (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No (Date of

Was there an autopsy?

What test confirmed diagnosis? Physician.

(Signed) F E Smith, M. D.

Nov 26 1920 (Address) 1313 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	Nov 28 1920
20 UNDERTAKER	ADDRESS
Jno C H. Chase Sons	1400 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

2048448 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048448

CERTIFICATE OF DEATH.

182

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1440 Mt Pelier ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard J Laisure

(Residence in Baltimore: No. 1440 Mt Pelier St.; unknown yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1899 (Year)

7-AGE, 21 yrs. mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): N. Dakota

PARENTS.

10-NAME OF FATHER, Isaac Laisure

11-BIRTHPLACE OF FATHER (State or Country): Mo.

12-MAIDEN NAME OF MOTHER: Edith Gemmill

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Laisure

(Address) 1440 Montpelier st

15-

FILED NOV 28 1920, 191.. ROBERT J. HAUTER Registrar.

Burial Permit Oleyd

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Rifle

Not (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Wm. H. Forkey M. D. (Coroner.)

11-26, 1920 (Address) 4 E. Oliver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem. DATE OF BURIAL, Nov. 29, 1920

20-UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048449 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048449

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 W. Lafayette Ave. ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle H. Jones,

(a) RESIDENCE. NO. 1128 W. Lafayette Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J.T.Lee Jones

6 DATE OF BIRTH (month, day, and year) Feb.16, 1868,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Hogge,

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda M.Graham,

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant J. T. Lee Jones
(Address) 1128 W. Lafayette Ave.

15 Filed NOV 28 1920 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to , 1920, that I last saw h[illegible] alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uretes with abdominal metastases.

(duration) 1 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic exam.

(Signed) John T. King Jr. M. D.

19 (Address) 11 E. Chase St., Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov.29.1920
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

2048450

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048450

CERTIFICATE OF DEATH.

115

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. University Hospital 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gesalo

(Residence in Baltimore: No. 1108 Auburn St Hanbert St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE 41 yrs. 0 mos. 0 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Iron Moulder

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Valeryo Gesalo

(Address) 1103 Hanbert

15- NOV 28 1920 ROBERT L KRAUTER

Filed....., 191.... Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1920, to Nov. 27 1920, that I saw him alive on Nov. 27 1920, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

a. Cute Catarrhal Jaundice

with Toxemia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. D. Owens M. D.

Nov. 27 1920 (Address) Union Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Nov 30, 1920

UNDERTAKER Wm Fallon & Co

ADDRESS 1118 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Janicki

D48451 HEALTH DEPARTMENT—CITY OF BALTIMORE D48451

CERTIFICATE OF DEATH. 175-005

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Hopkins Hospital, WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josef Janicki

(Residence in Baltimore: No. 253 S Regester St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Boy

6-DATE OF BIRTH, Unknown, (Month) (Day) 1 (Year)

7-AGE, 11 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Paul Janicki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Wladyslawa Herg

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Janicki

(Address) 253 S. Regester

15- NOV 28 1920 Filed....., 191.... ROBERT B KRAUTER Burial Permit Officer Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Concussion of brain by a Wagon

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. K. Davison M. D. (Coroner.)

11/29, 1920 (Address) E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary

DATE OF BURIAL, 11/30, 1920

20-UNDERTAKER Wm Hall & Son

ADDRESS 1608 Caroline

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L048452 HEALTH DEPARTMENT--CITY OF BALTIMORE L048452

CERTIFICATE OF DEATH

64 REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1648 N. Smallwood ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Levinson

(Residence in Baltimore: No. 1648 N. Smallwood St.: 28 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female | 4-COLOR OR RACE: white | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6-DATE OF BIRTH: [illegible], 1842 (Month) (Day) (Year)

7-AGE: 78 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: housewife 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Isaac Klein

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Fanny (Klein)

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sina Levinson

(Address) 2303 Eutaw Place

15 Filed NOV 28 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 26, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1920, to Nov 26 1920, that I saw her alive on Nov. 25-a 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(Duration) ... yrs. ... mos. 3, ... ds

Contributory (SECONDARY) Chronic myocarditis

(Duration) many yrs. ... mos. ... ds.

(Signed) David J. Mallet M. D.

Nov. 26, 1920 (Address) 3420 Underwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence 1645 N Smallwood st

19-PLACE OF BURIAL OR REMOVAL: Hebrew Washington Pk | DATE OF BURIAL: Nov 28, 1920

20-UNDERTAKER: Sol Levinson | ADDRESS 1914 Madison ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

148453 HEALTH DEPARTMENT—CITY OF BALTIMORE 148453

CERTIFICATE OF DEATH

REGISTERED No. C 29

1 PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Ellen V. Page~~ Guilford Apts. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME ~~Guilford Apartments~~ Ellen Page

(Residence in Baltimore: No. Guilford Apartments Guilford Ave. St.) 6 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct (Month) 14 (Day), 1835 (Year)

7-AGE, 85 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 700
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Frederick Co. Md

PARENTS.

10-NAME OF FATHER, Chr. W. Wirt.

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Elza Platt.

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. Page

(Address) Guilford Apartments

15 NOV 28 1920 Filed....., 191.... ROBERT B KRAUTER Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Duration ..... yrs. ..... mon. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Edema

Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Riley M. D.
(Coroner.)

Nov. 27, 1920 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Garrison Forest	Nov. 29, 1920

20-UNDERTAKER	ADDRESS
Henry W. Jenkins Sons	Mt. Washington Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048454 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048454

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. St. Agnes College ST.; 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Borgia Leonard

(a) RESIDENCE. NO. Mt. St. Agnes College ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Mercy

(b) General nature of industry, business, or establishment in which employed (or employer): 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: William Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Sr. M. Bernelita
(Address): Mt. Washington

15 Filed NOV 28 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to Nov 26, 1920, that I last saw h er alive on Nov 25, 1920, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin G. Weaver, M. D.

11/27, 1920 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Convent Cem.-Mt Washington	11-28 1920
20 UNDERTAKER	ADDRESS
Henry W. Kerkmeyer's Sons Co	McCulloh Orchard

N. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048455 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048455

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1313 Linden Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vanhoy A. Thompson

(a) RESIDENCE. No. 1313 Linden Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~ ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne Co (State or country) Md.

PARENTS

10 NAME OF FATHER Gustavus A. Thompson

11 BIRTHPLACE OF FATHER (city or town) Queen Anne Co (State or country) Md

12 MAIDEN NAME OF MOTHER Mary M. Zane

13 BIRTHPLACE OF MOTHER (city or town) Germantown (State or country) Pa

14 Informant William J. Thompson (Address) 1305 Linden Ave.

15 Filed NOV 28 1920 ROBERT E. LEE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25th, 1920, to Nov 26, 1920, that I last saw him alive on Nov 26th, 1920, and that death occurred, on the date stated above, at 5.20 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY —

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) E. M. Van Nop-, M. D.

11.27. 1920 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 29 1920
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons Co	McCulloh & Orchard

should be stated EXACTLY. ... may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2048456 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 858 W Balto St. ST.: 18 WARD) 79
REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Marshall
(Residence in Baltimore: No. 858 W Balto St Ste yrs., mos. 1 ds.) 73

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov (Month) 25 (Day), 1847 (Year)

7-AGE, 73 yrs. 0 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Md

PARENTS.
10-NAME OF FATHER, John Marshall
11-BIRTHPLACE OF FATHER, (State or Country). Md
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mabel Marshall
(Address) 858 W Balto St

15-
Filed NOV 28 1920, 191.... ROBERT B KRAUTER Registrar.
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular disease of the Heart (Duration) Dont Know ds.
CONTRIBUTORY (Secondary) Dont Know of any (Duration) ....yrs....mos....ds.

(Signed) W. K. Gorman M. D. (Coroner.)
11-27, 1920 (Address) 417 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?....
Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Nov 29 22, 1920
20-UNDERTAKER Mr & Mrs John H Teufel	ADDRESS 20 W Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048457

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 79

048457

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Cole ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Holcombe

(a) RESIDENCE. No. 219 Cole ave ST., WARD. New London Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Henry Holcombe

6 DATE OF BIRTH (month, day, and year) December 18th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housekeeper~~ None

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co Md

PARENTS

10 NAME OF FATHER George Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Lydia A Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co Md

14 Informant Mrs Lydia MacKay

(Address) 219 Cole ave Residence

15 Filed NOV 28 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov. 27, 1920, that I last saw h[illegible] alive on Nov 24. , 1920, and that death occurred, on the date stated above, at 4.05 a. m.

The CAUSE OF DEATH* was as follows:

~~Pulmonary~~ Chronic Endocarditis. ✓

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Williamson, M. D.

11/27 1920 (Address) Reifsnyder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL	DATE OF BURIAL
New London Pennsylvania	Nov 29th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

INSTRUCTIONS: This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOONAN

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948458 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948458

92-079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1207 Riverside ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Noonan

(a) RESIDENCE. No. 1207 Riverside Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town). Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robert E Noonan

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Maria N. Korsten

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Robert E Noonan
(Address) 1207 Riverside Ave

15 Filed NOV 28 1920 ROBERT F KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/20 19

17 I HEREBY CERTIFY, That I attended deceased from 11/24/20, 19, to 11/26/20, 19,

that I last saw h[illegible] alive on 11/26/20, 19,

and that death occurred, on the date stated above, at 3.45P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical Findings

(Signed) J. Fawcett Norris, M. D.

11/26, 1920 (Address) 1430 Riverside ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C & C Co	11-28 1920
20 UNDERTAKER	ADDRESS
Earl B Hoke	415 E Monument

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

2048459 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048459

CERTIFICATE OF DEATH.

109-09 2

REGISTERED NO. C

1-PLACE OF DEATH St Lunch Home & Infirmary.

CITY OF BALTIMORE: (No. North Broadway ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Noel

(Residence in Baltimore: No. 1012 Union Ave St.; 28 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 13 (Day), 1890 (Year)

7-AGE, 30 yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). D.31

9-BIRTHPLACE, (State or Country), Adams Co Pa

PARENTS.

10-NAME OF FATHER, Francis X Noel

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary E. Clunk

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary E Fowler

(Address) 1012 Rhinedale

15- NOV 28 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

Burial Permit Given

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1920, to Nov 26 1920, that I saw h last alive on Nov 26 1920, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia (Operation) Inguinal

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Walter T Anderson M. D.

Nov 28, 1920 (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deatbs from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Govans. DATE OF BURIAL, Nov 30, 1920

20-UNDERTAKER A J Marshall ADDRESS 3539 Taft Rd

Wm E. Hess

D48460 HEALTH DEPARTMENT—CITY OF BALTIMORE D48460

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 616 Fremont Ave ST.: 1 WARD)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. E. Hess

(Residence in Baltimore: No. 616 Fremont Ave St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word): Married

6-DATE OF BIRTH: Jan 17, 1894
(Month) (Day) (Year)

7-AGE: 26 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Self D86

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.
10-NAME OF FATHER: W E Hess.
11-BIRTHPLACE OF FATHER (State or Country): Baltimore
12-MAIDEN NAME OF MOTHER: Not known
13-BIRTHPLACE OF MOTHER (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. Cittern
(Address) 1847 Collington Ave

15-
Filed NOV 28 1920, 191.. ROBERT F. KRAUTER Burial Permit (Redacted)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Wounds by bullets of
Unknown
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Henry Fiss Ruby M. D.
(Coroner.)
Nov 26, 1920. (Address) 1627 Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery
DATE OF BURIAL, Nov. 30, 1920

20-UNDERTAKER P. Henry Lutz
ADDRESS 1007 N. Bond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48461 HEALTH DEPARTMENT—CITY OF BALTIMORE D48461

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1349 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Holland

(a) RESIDENCE. NO. 1349 Woodyear ST., WARD. Balto. Co. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Century

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Minnie Tolson

(Address) 1349 Woodyear ST

15 NOV 28 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1920, to Nov 27, 1920, that I last saw h— alive on Nov 27, 1920, and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis?

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

28, 1920 (Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinedale Cemetery	Nov 29 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1903 FREEMAN ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48462 HEALTH DEPARTMENT—CITY OF BALTIMORE. D48462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sefton Ave near Glenmore Ave ST.; 29 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Henry Hoerr

(Residence in Baltimore: No. Sefton Ave near Glenmore Ave St.; 1 yrs., mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 16 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 12 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John P. Hoerr

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Minnie V Bebras

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Hoerr

(Address) Hamilton Md.

15-NOV 28 1920 ROBERT B KRAUTER

Filed....., 191... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 2 1920, that I saw h— alive on Nov 27 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) yrs. 0 mos. 12 ds.

(Signed) Geary W Jones M. D.

Nov 28, 1920 (Address) 27 Hartford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Nov 29th, 1920
20-UNDERTAKER	ADDRESS
Fred Lossa & Son	Fullerton Md.

N. B.—Every item of information should be carefully supplied. AGE should be carefully calculated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D48463 HEALTH DEPARTMENT—CITY OF BALTIMORE D48463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 175-004 REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Martin

(Residence in Baltimore: No. 708 Beaumont Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug 15th, 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Martin

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Not Given

13-BIRTHPLACE OF MOTHER (State or Country). Not Given

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Martin

(Address) 708 Beaumont Ave

15- NOV 28 1920 ROBERT E LEAUTER

Filed ....., 191.. Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and, from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Shot Gun Accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Badly Shot

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Miller M. D.
(Coroner.)

11/27/20, 191... (Address) 432 Cross

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Nov 29, 1920

20-UNDERTAKER	ADDRESS
G. H. Enoch & Son	511 Hillsdale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948464 1948464

CERTIFICATE OF DEATH.

25

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frowey Yurik

(a) RESIDENCE. No. 816 Alice Anna St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
21 11/12	21	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigarette Braider

(b) General nature of industry, business, or establishment in which employed (or employer) — 017

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Frank Yurik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Fuschnac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Katherine Yurik (Address) 816 Alice Anna

15 Filed NOV 28 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17

I HEREBY CERTIFY, That I attended deceased from May 7 1920, to Nov 25 1920, that I last saw h Ex alive on Nov. 25 1920, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Actinomycosis involving neck & occipital regions with probable involvement of central nervous system. (duration) yrs. 6 mos. 20 ds.

CONTRIBUTORY (Secondary) Pulmonary edema. (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes — Date of July 19 — Oct 26 2-7. July 3rd

Was there an autopsy? No.

What test confirmed diagnosis? Bacteriological

(Signed) Henry H. Plaut, M. D.

11/25 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
B. Stanislaus	Nov 29 19
20 UNDERTAKER Millard B Callender	ADDRESS Bond & Ann Sts

#7257

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc. 6-9-19—H. P. Co.—1000 Bks.

48465 HEALTH DEPARTMENT—CITY OF BALTIMORE 48465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.; 9 WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Delia Greene

(a) RESIDENCE. NO. 507 Franklin St. Md. ST., WARD. St Marys Hall

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married Mr. Bernard Greene

6 DATE OF BIRTH (month, day, and year) Nov 26 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sewing 069

(b) General nature of industry, business, or establishment in which employed (or employer): Sewing

(c) Name of employer: Do not know

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Mr. Richard Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know Ireland

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Mary L. Mrs Sullok

(Address) 507 Franklin Square

15 [illegible]

NOV 29 1920

ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1920

17

I HEREBY CERTIFY, That I attended deceased from 9-11, 1920, to 11-26, 1920, that I last saw her alive on 11-26, 1920, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Polyserositis acute

(duration) yrs. 3 mos. 21 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Craig, M. D.

11-26 1920 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov 29 1920

20 UNDERTAKER: Geo. Weber & Son ADDRESS: 2303 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Anasarca

1048466 HEALTH DEPARTMENT--CITY OF BALTIMORE 1048466

CERTIFICATE OF DEATH

x 92

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 2501 W. North Ave ST.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bessie Elizabeth Bacon

(Residence in Baltimore: No. 2501 W. North Ave St.: ... yrs. 1 mos. 20 ds.)

WRITE PLAINLY, WITH INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word) Married

6 DATE OF BIRTH Jan 18 (Month) (Day), 1880 (Year)

7 AGE 40 yrs. 10 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9 BIRTHPLACE (State or country) Stockport Ohio.

PARENTS

10 NAME OF FATHER James F. C. Teal

11 BIRTHPLACE OF FATHER (State or country) Stockport Ohio.

12 MAIDEN NAME OF MOTHER Hannah Anderson

13 BIRTHPLACE OF MOTHER (State or country) Stockport Ohio.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest L. Bacon

(Address) 2501 W. North Ave

15 NOV 29 1920 filed ..... 191 ..... ROBERT N. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 28 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Nov 28 1920, that I saw h[illegible] alive on Nov 26, 1920, and that death occurred, on the date stated above, at 3.35 P. m. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 1 ds

Contributory (SECONDARY) Infected Knee

(Duration) ... yrs. ... mos. 4 ds.

(Signed) E Virden Schindler M. D.

Nov 28, 1920 (Address) 2129 N Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Former or usual residence Stockport Ohio

19 PLACE OF BURIAL OR REMOVAL Stockport Morgan Co Ohio DATE OF BURIAL Nov 29th 1920

20 UNDERTAKER Pottsamwyne ADDRESS 1723 N Lafayette

048467 HEALTH DEPARTMENT—CITY OF BALTIMORE 048467

CERTIFICATE OF DEATH.

(PLACE OF DEATH 578 Radnor Ave
CITY OF BALTIMORE (No. Evans ST.: 27 WARD) REGISTERED NO. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen N Russell

(Residence in Baltimore: No. 578 Radnor Ave. St.) 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 8, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or estsblishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Stephen Spros

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Raiph Hurst

13-BIRTHPLACE OF MOTHER (State or Country), N Y

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Russell

(Address) 578 Radnor Ave

15-

Filed NOV 29 1920 ROBERT B KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

11-29-20 101 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pres Lutheran Cem. Govans

DATE OF BURIAL, Nov 29, 1920

20-UNDERTAKER Wm Cook

ADDRESS N + G Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lbs.

1048468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64/1048468

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Edmondson ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Gilbert Morton

(Residence in Baltimore: No. 1929 Edmondson ave St.; 27 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be filled EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 22 (Day) 1851 (Year)

7-AGE, 69 yrs. 1 mos. 5 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)..... B.R.Co

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER W. Eugene Morton

11-BIRTHPLACE OF FATHER (State or Country), Carolina

12-MAIDEN NAME OF MOTHER Sarah E. Sheppard

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Attaway Morton

(Address) 1929 Edmondson

15-

Filed NOV 23 1920 191.....

ROBERT B. KRAUTER
Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19th 1920, to Nov 27th 1920, that I saw him alive on Nov 27th 1920, and that death occurred, on the date stated above, at 5:55 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Hammer M. D.

Nov 28th, 1920. (Address) 1927 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1929 Edmondson ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 1st, 1920.

20-UNDERTAKER William Cook & Co — ADDRESS 502 E. North ave

Spec.—6-9-19—H. P. Co.—1000 lks.

048469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 048469

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 N. Linwood St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin L. Livingston.

(a) RESIDENCE. No. 617 N. Linwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Livingston

6 DATE OF BIRTH (month, day, and year) Apr 5. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57.	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James H Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna E. Kellum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma M Livingston
(Address) 617 N Linwood Ave

15 Filed NOV 29 1920 ROBERT I. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Nov 26 1920

that I last saw h[illegible] alive on Nov 26. 1920

and that death occurred, on the date stated above, at 10P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray & findings

(Signed) [illegible] M. D.

19 (Address) 8000 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: Nov 29 1920

20 UNDERTAKER: Woodcock & Son ADDRESS: E Fayette & Madison St

Dr Ruzicka Patterson Park Ave & Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948470 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948470

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1141 Fillmore ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Walker

(a) RESIDENCE. NO. 1141 Fillmore ST., WARD.

(Usual place of abode) Wife

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Sabastian J. Walker

6 DATE OF BIRTH (month, day, and year): Aug 23-1829

7 AGE: Years 90 Months 3 Days 4 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Ella Watkins

(Address) 1141 Fillmore St

15 Filed NOV 29 1920 ROBERT J. CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 27/20

17 I HEREBY CERTIFY, That I attended deceased from Oct 11 1920, to Nov 27 1920, that I last saw her alive on Nov 27 1920, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ....yrs. ? mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. Dungan M.D. M. D.

Nov 27/20 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Nov 30 1920

20 UNDERTAKER: William Cook — ADDRESS: 5126 York

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of MEDICAL INFORMATION should be carefully supplied. AGE it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL INFORMATION on back of certificate. See instructions on back of certificate. See instructions on back of certificate. INFORMATION is very important. See instructions on back of certificate. INFORMATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

2048471 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048471

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Caswell ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald D Fifer

(a) RESIDENCE. No. 1526 Caswell ST., E. WARD.

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Elizabeth B. Fifer

6 DATE OF BIRTH (month, day, and year) Nov 2[illegible]-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	-	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Powell (Address) 1526 Caswell St.

15 Filed NOV 29 1920 ROBERT I. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 27 1920

17 I HEREBY CERTIFY, That I attended deceased from November 21, 1920, to November 27, 1920, that I last saw him alive on Nov 26, 1920, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Yes

(Signed) H. Maury Whitbeck, M. D.

, 19 (Address) 1417 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Nov. 29 1920
20 UNDERTAKER William Cook	ADDRESS 502 S. Mott

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Blks.

1531 E. N Ave.

D48472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D48472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1752 Homestead ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarilla R. Stones

(a) RESIDENCE. NO. 1752 Homestead ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rufus Stones

6 DATE OF BIRTH (month, day, and year): Nov 9 - 1851

7 AGE: Years 69 Months Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jeremiah Hoelbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Matilda Hyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Addison Stones (Address) 1752 Homestead St

15 Filed NOV 29 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1918, to Nov. 26, 1920, that I last saw h[illegible] alive on Nov. 26, 1920, and that death occurred, on the date stated above, at 9 20 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted, if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Reynolds M. D.

Nov. 29 1920 Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Nov 29 1920

20 UNDERTAKER: Wm Cook — ADDRESS: W + G Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION IS REQUIRED BY LAW. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPAY be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be CAUSE OF DEATH is very important. See instructions on back of certificates. TION is very important. See instructions on back of

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

048473 HEALTH DEPARTMENT—CITY OF BALTIMORE 048473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Or, if on way to) U. S. D. — 175-001

CITY OF BALTIMORE (No. ..... St.: 15 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick F. Pfeiffer Jr.

(Residence in Baltimore: No. 3028 W. North Ave. St.; yrs., 7 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, May (Month) 14 (Day), 1913 (Year)

7-AGE, 7 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frederick F. Pfeiffer Sr.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Vashti L. Kemp.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. F. Pfeiffer Sr.

(Address) 441 E. 20th St.

15-

Filed ..... 191.....

NOV 29 1920 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said us- (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull (automobile accident) (Instant death)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. T. Hennessey M. D. (Coroner.)

Nov. 27 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the U. S. Commenced dead. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 29 1920
20-UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

D48474 HEALTH DEPARTMENT—CITY OF BALTIMORE D48474

150

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 N. Carrollton Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Greene

(Residence in Baltimore: No. 1017 N. Carrollton Ave St.; yrs., 2 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, October (Month) 1 (Day), 1920 (Year)

7-AGE, ...yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER, Robt. Green

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Susie Rogus

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hinson

(Address) 1017 N. Carrollton Ave

15- NOV 29 1920 Filed, 191. ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. D. Hemmeter M. D. (Coroner.)

Nov 26, 1920 (Address) 2802 Druid Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19..
Loudon Park	Nov 29 20
20-UNDERTAKER	ADDRESS
Smith O'Keefe	Mount Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D48475
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Franklin Square Hospital ST. 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H White

(Residence in Baltimore: No. 700 N Payson St.: yrs., 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. Sept (Month) 23 (Day), 1897 (Year)

7-AGE. 23 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Toronto Canada

PARENTS.

10-NAME OF FATHER, George White
11-BIRTHPLACE OF FATHER (State or Country), England
12-MAIDEN NAME OF MOTHER Anne Salden
13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George White
(Address) Toronto Canada

15- NOV 29 1920 ROBERT P KRAUTER
Filed ....., 191... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Richard Poisoning
.....
..... (Duration) .....yrs.....mos.....ds.
CONTRIBUTORY (Secondary) Accidental
..... (Duration) .....yrs.....mos.....ds.

(Signed) James M Hinton M. D.
(Coroner.)
Nov 29 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death .....yrs.....mos. 7 ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? Baltimore Md
Former or usual residence 700 N Payson St

19-PLACE OF BURIAL OR REMOVAL, Toronto Canada — DATE OF BURIAL, Dec 1, 1920

20-UNDERTAKER Gott Brothers & Son — ADDRESS 175 Calhoun

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

I have Examined this
Cutpiab & find it
Ok, from Evidence
Whether it was probly
accidental taken in
mistake for aspirin
Jno W Fenton
Too & Chas T

Spec.—6-9-19—H. P. Co.—1000 Bks.

048476 HEALTH DEPARTMENT—CITY OF BALTIMORE 048476

CERTIFICATE OF DEATH.

115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 S Grove ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Stefanski

(a) RESIDENCE. NO. 820 S Grove ST. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 837

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michal Wilenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Wilinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Stefanski
(Address) 820 S Grove St

15 Filed NOV 29 1920 ROBERT J. BRAUER Registrar
Burial Permit Issued

N. B.—WRITE PLAINLY WITH LEAD PENCIL. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Nov. 27, 1920, that I last saw ~~her~~ alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 11-15 p m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C Earl Neer, M. D.

, 19 (Address) 404 Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov. 30 1920
20 UNDERTAKER	ADDRESS
Stephen J Falkowski	1005 Spring Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48477 HEALTH DEPARTMENT—CITY OF BALTIMORE D48477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Division St.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Bowie

(a) RESIDENCE NO. 1824 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Bowie

6 DATE OF BIRTH (month, day, and year) Abt. 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt. 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Cook in private Family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Wm A. Cummings 1824 Division St.

15 Filed NOV 29 1920 ROBERT A. CARTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Nov 26th, 1920, that I last saw h er alive on Nov 26th, 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Known

(Signed) Gustav Lotzman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 29, 1920
20 UNDERTAKER	ADDRESS 1234
Jno. M. Johnson	Etting St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

McGahan

D 48478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

115 D 48478

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. University Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Helen M. McGahan

(Residence in Baltimore: No. #2318 N. Charles St. St.; 15 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November (Month) 16 (Day), 1884 (Year)

7-AGE, 36 yrs. 0 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country) Perryman Md.

PARENTS.

10-NAME OF FATHER, Jas. H. Malcolm

11-BIRTHPLACE OF FATHER (State or Country), Perryman Md

12-MAIDEN NAME OF MOTHER Mary E. Michael

13-BIRTHPLACE OF MOTHER (State or Country), Perryman - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M. Gahan (husband)

(Address) 2318 N. Charles St

15- NOV 29 1920 Filed....., 191.....

ROBERT B. KRAUTH
DEPUTY REGISTRAR
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Nov 26 1920, that I saw her alive on Nov 26 1920, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Uremia
(b) Toxemia of Pregnancy
(c)
(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Unpreventable Insufficiency

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Jos. C. Geyer M. D.

Nov 26, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 4 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? #2318 N. Charles St.

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, Nov 29, 1920

20-UNDERTAKER STEVENS & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 48479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48479

CERTIFICATE OF DEATH.

138

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospitals ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah E. Justis

(Residence in Baltimore: No. 1606 Mt. Royal Ave. St.; 34 yrs., 1 mos. 21 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept. (Month) 7 (Day), 1886 (Year)

7-AGE, 34 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Stallings.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elenor E. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Devallington

(Address) Womans Hospital.

15- Filed NOV 29 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Nov. 28 1920, that I saw h e alive on Nov. 28 1920, and that death occurred, on the date stated above, at 3.25 A.M.

The CAUSE OF DEATH* was as follows: OVER

Eclampsia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank Devallington M. D.

Nov. 28, 1920 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 34 yrs. 1 mos. 21 ds.

Where was disease contracted, if not at place of death? 7

Former or usual residence 1606 mt Royal Ave

19-PLACE OF BURIAL OR REMOVAL, Greenlawn Cemetery — DATE OF BURIAL, Nov 30 1920

20-UNDERTAKER STERLING E. MOWEN COMPANY (WILLIAM F. WOODEN, SUCCESSOR) — ADDRESS 108 W. NORTH AVE.

Spec.—8-24-14—M. & T.—2000 Bks.

D 48480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48480

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3616 Ook St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Artemus Whitehead

(Residence in Baltimore: No. 3616 Ook St. St.; 5 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Widow

6-DATE OF BIRTH, July (Month) 2 (Day), 1866 (Year)

7-AGE, 54 yrs. 4 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Gustavus Whitehead

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Conley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Whitehead

(Address) 3616 Ook St

15- NOV 29 1920 Filed, 191

ROBERT B. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1919, to Nov 28 1920, that I saw h[illegible] alive on Nov 27th 1920, and that death occurred, on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Epilepsy

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile

Duration ? yrs. mos. ds.

(Signed) I. H. Lillard M. D.

Nov 28th, 1920 (Address) 1727 Mich Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fairsel Md	Nov 30 1920
20-UNDERTAKER	ADDRESS
Ashenover & Son	Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Blks.

1048481 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1048481

CERTIFICATE OF DEATH.

REGISTERED NO. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lillian McCairns

(Residence in Baltimore: No. #136 E. Clement St. St.; East yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, (MARRIED), WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November 16, (Month) (Day) 1874 (Year)

7-AGE, 46 yrs. 20 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 83

9-BIRTHPLACE, (State or Country), Wilmington Del.

PARENTS.

10-NAME OF FATHER, Powell Clayton

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Drucilla Yeblay

13-BIRTHPLACE OF MOTHER (State or Country), Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary K Kairns

(Address) 136 E Clement St

15- Filed NOV 29 1920, 191... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 26 1920, that I saw her alive on Nov 26 1920 and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia & Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Transverse Presentation Labor for Toxemia of Pregnancy

(Duration) yrs. mos. ds.

(Signed) Wm Gerber M. D.

, 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? University Hospital

Former or usual residence # 136 E Clement St.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Nov 29., 1920

20-UNDERTAKER John F Denny

ADDRESS 715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48482 John Palmer D48482

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE (No. 2 W. Conway St. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Palmer. (C)

(Residence in Baltimore: No. 2 W. Conway St. St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
35 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Gulf, N.C.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Wilson. (C)

(Address) 2 W. Conway St.

15- NOV 29 1920 ROBERT B KRAUTER

Filed..... 191..... Registrar.
Burial Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 25th. 1920. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) inquiry find that said deceased came to ner death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Pulmonary Hemorrhage.
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto C. Eppard M. D.
(Coroner.)

Nov. 26., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	11-29, 1920
20-UNDERTAKER	ADDRESS
Mrs. Geo. H. Hooper	406 Conway St

D 148483 HEALTH DEPARTMENT—CITY OF BALTIMORE D 148483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. C 171

CITY OF BALTIMORE (No. ..... St.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Buchholz.

(Residence in Baltimore: No. 131 N 10th

Ot.; yrs.. 77 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, January 28, 1883
(Month) (Day) (Year)

7-AGE, 35 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Frederick Buchholz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie Brookek

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Buchholz

(Address) 131 N 10th St

15- NOV 29 1920 Filed ....., 191.... ROBERT E KRAUTER Burial Permit Officer Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident.

Incised Wound Thigh

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Haemorrhage Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Hodge M. D.
(Coroner)

Nov 25, 1920 (Address) 432 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Nov 29 1920
20-UNDERTAKER John Herold & Co	ADDRESS 2118 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Henry J. McCahan. ✓ 1048484

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048484 HEALTH DEPARTMENT—CITY OF BALTIMORE 45

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Henry J. McCahan

(a) RESIDENCE. NO. 2102 Barclay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary for Knights of Columbus

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry McCahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Breanna Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Green
(Address) 2102 Barclay St.

15 Filed NOV 29 1920 ROBERT B. KRAUTER Registrar
Burial Permit Otrs

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Nov 28 1920, that I last saw h alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emma L. Roddy, M. D.

Nov 24 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/1 1920

20 UNDERTAKER Chas. J. Evans & Son ADDRESS 118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

648485 HEALTH DEPARTMENT—CITY OF BALTIMORE 648485

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3411 E. Balto. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stewart Russell Fraler

(a) RESIDENCE. No. 3411 E Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 8 1920

7 AGE — Years: — Months: 8 Days: 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: George A. Fraler

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: agnes M. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: agnes M Fraler

(Address): 3411 E. Balto St

15 Filed NOV 29 1920 ROBERT B. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from nov. 25, 1920, to nov. 27, 1920, that I last saw h[e] alive on nov 27, 1920, and that death occurred, on the date stated above, at 4 am.

The CAUSE OF DEATH* was as follows:

Enteritis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? does not know.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. Karl Jones, M. D.

, 19 (Address) 2958 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	11/29 1920
20 UNDERTAKER	ADDRESS 3000
J. A. Moran	E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1048486 151 ✓ 1048486

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 S Decker Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Kelly

(Residence in Baltimore: No. 644 S Decker Ave St.; ..... yrs., ... mos. 4 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY, with INK. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... 11 (Month) ..... 24 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
.....yrs.....mos. 4 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Kelly

11-BIRTHPLACE OF FATHER (State or Country), U S

12-MAIDEN NAME OF MOTHER Barbara Creamer

13-BIRTHPLACE OF MOTHER (State or Country), U S

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Kelly

(Address) 644 S Decker Ave

15- ROBERT B KRAUTER

NOV 29 1920 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 11 (Month) ..... 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-24 1920, to 11-28 1920, that I saw him alive on 11-27 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 Mo.)

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) Elijah J Russell M. D.

11-28, 1920 (Address) 156 N Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pennsylvania	11/29, 1920
20-UNDERTAKER J J Inman	ADDRESS 2000 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048487

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048487

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No St Josephs Hospital ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kennedy #2

(a) RESIDENCE. NO. 1008 E Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Dennis Kennedy

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Debarry

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Dr W Brennan
Address 2431 Calvert St

NOV 26 1920

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 19 20, to Nov 28, 19 20, that I last saw him alive on Nov 27, 19 20, and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital debilitaus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Premature (8 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Dr W Brennan, M. D.

, 19 (Address) 2431 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Nov 29 1920
20 UNDERTAKER E A Kirchfeld	ADDRESS 501 E 22 St

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048488

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048488

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wahl

(a) RESIDENCE. No. 2120 Orleans ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? life yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J Wahl

6 DATE OF BIRTH (month, day, and year) July 17—1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hoerner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George J Wahl. (Address) 2120 Orleans St

15 Filed NOV 29 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1918, to Nov 25, 1920, that I last saw h[illegible] alive on " " 1920, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 6 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gallstones

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Heaver, M. D.

27. 1920 (Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 29 1920
20 UNDERTAKER	ADDRESS
Mrs C. Miller	2334 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in this state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048489

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048489

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1946 Light St., ST.: 23 WARD)

2-FULL NAME Bertie Mahoney

(a) RESIDENCE. NO. 1946 Light ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Mahoney

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant William Mahoney
(Address) 1946 Light St.

15 Filed NOV 29 1920 ROBERT E. KRAETER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Nov 25, 1920, that I last saw h[illegible] alive on Nov 25, 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Tuberculosis meningitis
Of months

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? In Bed

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Finn, M. D.

2[illegible] 1920 (Address) 1308 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12/9 1920
20 UNDERTAKER	ADDRESS
A. F. Bishop & Son	1318 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 48490 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48490

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mun Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Lewis

(Residence in Baltimore: No. Mun Hospital St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Jan 1 1907, 1
(Month) (Day) (Year)

7-AGE, 11 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school girl
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Lotts Cuy Va

PARENTS.

10-NAME OF FATHER, Thos E Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Eva E Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos E Lewis

(Address) 53 W Lanvale

15-

Filed NOV 29 1920, 191 ROBERT E KRAUTER Registrar.

Burial Permit 0550

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronc. Pneumonia 2d

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY, (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Lottsburg Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lottsburg Va	....., 19....
20-UNDERTAKER A H Wetske	ADDRESS 53 W Lanvale

Spec.—6-9-19—H. P. Co.—1000 Blks.

2148491 HEALTH DEPARTMENT—CITY OF BALTIMORE 2148491

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 95 Kelly place ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Ellsworth Patterson

(a) RESIDENCE. No. 95 Kelly place ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: "

6 DATE OF BIRTH (month, day, and year): Sept 21st 1919.

7 AGE — Years: 1 — Months: 2. — Days: 7. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md.

PARENTS

10 NAME OF FATHER: Edw. E. Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto city Md.

12 MAIDEN NAME OF MOTHER: May C. Stalk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto city Md.

14 Informant (Address): Edw. E. Patterson 95 Kelly place.

15 NOV 29 1920 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 28 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Nov. 28, 1920, that I last saw him alive on Nov. 28, 1920, and that death occurred, on the date stated above, at 720 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Diphtheria

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank H. Machin, M. D.

, 1920 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Crem. Hanfield — DATE OF BURIAL: 11/29. 1920

20 UNDERTAKER: J Walter Davis — ADDRESS: 3397 Paine at 330 Pm

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 48492

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 48492

CERTIFICATE OF DEATH

150

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Washington, ST.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Conkling

(Residence in Baltimore: No. Mt. Washington St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Nov. (Month) 27 (Day), 1920 (Year)

7-AGE: — yrs. — mos. 1 ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Mt. Washington

PARENTS

10-NAME OF FATHER: Wm. Higgins Conkling Jr.

11-BIRTHPLACE OF FATHER (State or country): Balto. Co. Md

12-MAIDEN NAME OF MOTHER: Mary Isabelle Patterson

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H Conkling Jr

(Address) Mt Washington Md

15

NOV 29 1920

[illegible] REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 28 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Nov. 28 1920, that I saw h[illegible] alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart (Patent foramen)

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice Lazenby M. D.

Nov 28, 1920 (Address) 1800 E. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge

DATE OF BURIAL: Nov 29 1920

20-UNDERTAKER: [illegible] Lucius Foster

ADDRESS: Edmondson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44585
D48493

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48493

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Thomas.

(a) RESIDENCE. NO. 209 Carling Town Ave Baltimore Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Lawrence Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Edith Diggs.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) J. H. Hospital Bmore

15 Filed NOV 29 1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27. 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23 1920, to Nov. 27. 1920, that I last saw her alive on Nov. 27. 1920, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Smear.

(Signed) W Davison, M. D.

, 19 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 29 1920
20 UNDERTAKER	ADDRESS
Samuel Hensley	578 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48494 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48494

91-081

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baybiew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Robinson

(a) RESIDENCE. No. 726 Pierce St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Baybiew Hospital (Address) Balto, Md.

15 Filed NOV 29 1920 ROBERT B. KLAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1920, to Nov. 25, 1920.

That I last saw h.. alive on Nov. 25, 1920, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith, M. D.

11/27/1920 (Address) Baybiew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. E. Cemetery	Nov 30 1920
20 UNDERTAKER Edward J. Hendley	ADDRESS 578 N Bradford

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 48495

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Mount ST.; 16 WARD)

2-FULL NAME Mary Hoel.

(a) RESIDENCE. No. 814 Mount st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

3a If married, ~~widowed, or divorced~~ (or) WIFE of Archibald Hoel

6 DATE OF BIRTH (month, day, and year) Dec 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Keeble

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Gosson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Archibald R Hoel
(Address) 814 N Mount St

15 Filed ... 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sep 5, 1920, to Nov 28, 1920, that I last saw her alive on Nov 28, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy - Cardiac Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wallis N White Jr, M. D.

19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 30 1920
20 UNDERTAKER W. M. Rondon.	ADDRESS 2238 N Arlington Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48496

HEALTH DEPARTMENT—CITY OF BALTIMORE

108 D 48496

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST.; 70 WARD)

2-FULL NAME Robert H Adams

(a) RESIDENCE. No. 528 S. Bentlow ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or . min.
	18.	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Backhaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William Adams (Address) 528 S. Bentalow St

15 Filed ..... 19 ..... Registrar

Buried [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-27 , 1920 , to 11-27 , 1920 ,

that I last saw him alive on 11-27 , 1920 ,

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis
Peritonitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-28-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. McKeag, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL 19

20 UNDERTAKER: H B Kephart — ADDRESS 2336 Frederick Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48497 D 48497

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3478 Smallwood ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A Schrader

(Residence in Baltimore: No. 3478 S. Smallwood St. St.: 45 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 30th, 1860 (Month) (Day) (Year)

7-AGE, 60 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): Drug

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Louis Schrader

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Keppelman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jeanetta Schrader

(Address) 3471 S. Smallwood St

15-

Filed NOV 29 1920, 191.., [illegible] Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 1920, to Nov. 26 1920, that I saw h-in alive on Nov 26 1920, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Walter S. Tibbitt M. D.

Nov 28, 1920. (Address) 2220 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Nov 29th, 1920

20-UNDERTAKER G B Wishart ADDRESS 2336 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County D48498

119 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. D48498

Village or City Hillsdale (No. 109 Main St. 26 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Albert H Haydon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH August 24 1894 (Month) (Day) (Year)

7 AGE 26 yrs. mos. ds. | If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer at the
(b) General nature of industry business, or establishment in which employed (or employer) Mills 040

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER John Haydon

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Vaan

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie V. Haydon

(Address) Hillsdale Md.

15 Filed NOV 29 1920 ROBERT B ARMUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 (Month) 26 (Day) 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1920, to Nov 26th, 1920, that I last saw him alive on Nov 26th, 1920, and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH * was as follows:

Acute Nephritis

(Duration) yrs. mos. 16 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) A. C. Emmert, M. D.

Nov 27th 1920 (Address) 4709 Rhode Island Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lorraine Cem | DATE OF BURIAL 11-30, 1920

20 UNDERTAKER A Rohrer Son | ADDRESS 600 Washington Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48499

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Chester St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Comen.

(a) RESIDENCE. NO. 119 S. Chester ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Comen.

6 DATE OF BIRTH (month, day, and year) April 27th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) of Balto. Copper

(c) Name of employer and Rolling Mill.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick Comen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Comen
(Address) 119 S. Chester St.

15 Filed ... Dec. 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Nov. 27, 1920, that I last saw him alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 12-9/8 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency (Renal)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 hrs. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl J. Zeigler, M. D.

Nov 28, 1920 (Address) 2002 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 30th 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe St

NOV 29 1920

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CHILD, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Fact of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48500

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4500 Belmont ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Eckhart

(a) RESIDENCE. No. 4500 Belmont ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or wife of~~) Emma Eckhart

6 DATE OF BIRTH (month, day, and year) april 25. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired D45

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Eckhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Emma Eckhart
(Address) 4500 Belmont ave

15 Filed ... 19 ... Registrar

NOV 29 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from april 24, 19 20, to Nov. 27 19 20, that I last saw h~~im~~er alive on Nov 27, 19 20, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Anaemia — Paravelyma — Stone in bladder

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Bron- chitis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas Dugan, M. D.

11/27, 19 20 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 30 1920
20 UNDERTAKER Zirkler + Zirkler	ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48501

91-32

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 4 WARD)

2-FULL NAME Jerome Cooke

(a) RESIDENCE. NO. 421 St. Paul Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thos. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cornelia Rock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant W. C. Davison
(Address) J. H. H. Balto Md

15 FILED NOV 29 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1920, to Nov. 26, 1920, that I last saw him alive on Nov. 20, 1920, and that death occurred, on the date stated above, at 2 P. M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Rachitis & Edema

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) W. C. Davison, M. D.

, 19 (Address) J. H. H. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	November 29 1920
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48502

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Pierce St. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Brown

(Residence in Baltimore: No. 1708 Pierce St. St.; ...yrs.,...mos.,...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown unknown; 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of Industry, business, or establishment in which employed (or employer): House Wife

9-BIRTHPLACE, (State or Country) born in Baltimore City

PARENTS.

10-NAME OF FATHER, Walter Clements

11-BIRTHPLACE OF FATHER (State or Country), Saint Marys County Md

12-MAIDEN NAME OF MOTHER Martha Griffin

13-BIRTHPLACE OF MOTHER (State or Country), born in Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Martha Clements

(Address) Atlantic City N.J.

15- Filed NOV 30 1920, 191...

Robert P. Harrison,
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27th 1920, to Nov 27th 1920, that I saw her alive on Nov 27th 1920, and that death occurred, on the date stated above, at 7.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Leonard Otto Olin M. D.

Nov 27th, 1920 (Address) 401 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, November 30, 1920

20-UNDERTAKER Wm R A Elliott

ADDRESS 1720 Ashland Ave

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION is very may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48503

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Wenzel

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Of Lizzie Lemp.

6 DATE OF BIRTH (month, day, and year) 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Wenzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Helena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence, Sister Valley

(Address)

15 Nov 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...

that I last saw h[im] alive on Nov 25, 1920.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

3 Days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Nov 27. 1920 (Address) 1132 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Nov. 30 1920
20 UNDERTAKER	ADDRESS
H. C. Medefield	914 Greenmount Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48504

CERTIFICATE OF DEATH.

X 172

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1415 Linden Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha M Clayton

(Residence in Baltimore: No. 1415 Linden Ave St.; ....yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, ... Jan. (Month) 11 (Day), 1829 (Year)

7-AGE, 91 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), A. A. Co Md

PARENTS.

10-NAME OF FATHER, John Clayton

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co

12-MAIDEN NAME OF MOTHER Mary McEvey

13-BIRTHPLACE OF MOTHER (State or Country), A a Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha M. Clayton

(Address) 1415 Linden Ave

15- Robert P. Harrison,

Filed (M. D.) ....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Nov 29 1920, that I saw h er alive on Nov 28 1920; and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fractured femur

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) C Lankenau M. D.

Nov 29, 1914 (Address) 132 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Harwood, A. A. Co. Md.

19-PLACE OF BURIAL OR REMOVAL, Dunmanway A. A. Co. DATE OF BURIAL, Nov. 30, 1914

20-UNDERTAKER ..... ADDRESS .....

Not attached 1205 N. Eutaw St

N.B.—Every item of information should be carefully supplied. Avoid abbreviations. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks *Was very old and demented, had an accidental fall while at her home in Anne Arundel Co., breaking her leg, and was brought to Balto. for treatment*

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Read statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48505 ~ HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48505 ~

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fed. Mil. Hosp. ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ait Chesnut

(a) RESIDENCE. No..... ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ♂

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Whitney Aitcheson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lina Boudant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: W. Aitcheson
(Address): Lansdowne

15 Filed NOV 25 1920, 19.....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Nov. 24, 1920, that I last saw h[illegible] alive on Nov. 24, 1920, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Oedema of Pregnancy.
Premature Delivery (7 mos.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis: Clinical Manifestations

(Signed) Fred B. Thurber, M. D.

, 19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parnell Hall	11/29 1920
20 UNDERTAKER	ADDRESS
J. Edmondson & Sons	13 E. Lex. St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48506 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48506

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Fulton Ave ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa N. Koch

(a) RESIDENCE. No. 503 N. Fulton Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

3 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Leonard Koch

6 DATE OF BIRTH (month, day, and year) Aug 14 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER (not known) Bohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Katie's Son (Daughter)

(Address) 1123 S. Edwards Ave

15 Filed NOV 29 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Nov 28, 1920, that I last saw her alive on Nov 27, 1920, and that death occurred, on the date stated above, at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Paralysis Agitans (duration) yrs. not known mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? albuminuria etc.

(Signed) W. W. Wright, M. D.

Nov 29 1920 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 30 1920
20 UNDERTAKER	ADDRESS
Josiah Seyfer	1600 at Gaith Ave

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

D.48507 HEALTH DEPARTMENT--CITY OF BALTIMORE D.48507

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C 64

CITY OF BALTIMORE (No. 1648 Appleton ST. 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Crum

(Residence in Baltimore: No. 1648 appleton st St.: 2/ Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female | 4-COLOR OR RACE White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH March (Month) 9 (Day), 1874 (Year)

7-AGE 46 yrs. 8 mos. 18 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Home 037
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Frederick, Md

PARENTS

10-NAME OF FATHER George Rolke

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Mary Jordan

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse H Crum

(Address) 1648 Appleton St

15 Robert P. Harrison,

Filed NOV 29 1920 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov (Month) 27 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to, Nov 27 1920,
that I saw h[er] alive on Nov 27, 1920,
and that death occurred, on the date stated above, at 10.40 m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 15 ds

Contributory (SECONDARY) General Condition, ? Blood pressure

(Duration) 1 yrs. mos. ds.

(Signed) B Banister Catlin M. D.

11/28/20. 1920 (Address) 1404 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lorraine Cemetery | DATE OF BURIAL Dec 1 1920

20-UNDERTAKER Josiah Lyser | ADDRESS 1600 N Monroe Ave

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48508 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48508

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 744 E. Fenton ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen F. Feehan

(a) RESIDENCE. NO. 744 E. Fenton ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Feehan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Claffey

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Miss Mary L. Feehan
(Address) 744 E. Fenton St

15 Filed NOV 29 1920 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1920, to Nov 27, 1920, that I last saw her alive on Nov 27, 1920, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nitric acid & microscopic

(Signed) Mary F. Vaeglens, M. D.

Nov 29, 1920 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Near Cathedral Cemetery — DATE OF BURIAL Dec 1 1920

20 UNDERTAKER Henry Hoeck & Son — ADDRESS 1301 E Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,48509 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,48509

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Johns Hopkins Hospital.

2-FULL NAME Baby Amos

(a) RESIDENCE. No. 1630 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1920

7 AGE: Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Payton Tutwiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Effie Amos.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C.W. Gray (Address)

15 Filed ..., 19 Robert P. Harrison Registrar

Burial Permit Clerk.

3/10 NOV 29 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Nov 24, 1920, that I last saw him alive on Nov 24, 1920, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Comm

ADDRESS NOV 29 1920

Par. Wm. E. WOODALL

0.48510 This body is now at University Hospital please send there & get body & remove to city Morgue & hold for a few days till his identity can be established

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

175-001 0.48510

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. University Hospital St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas W. Henderson

(Residence in Baltimore: No. Levering House city St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W.	Don't Know

6-DATE OF BIRTH, ... Don't Know (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
40 about yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0K7

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, ( )

11-BIRTHPLACE OF FATHER (State or Country), ( )

12-MAIDEN NAME OF MOTHER ( )

13-BIRTHPLACE OF MOTHER (State or Country), ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- NOV 29 1920 Filed ..... 191 Robert F. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, or~~ ~~autopsy~~ or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

a few hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accidentally struck by automobile

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Jarnel (Coroner) M. D.

11-16-, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, 1920
JOHNS HOPKINS HOSPITAL	NOV 21

20-UNDERTAKER Per. Wm. E. WOODALL ADDRESS Per. Wm. E. WOODALL

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48511 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48511

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 37 Guilford Alley. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Samuel Gales.(C)

(Residence in Baltimore: No. 37 Guilford Alley. St.; 1 yrs., ---- mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Single.

6-DATE OF BIRTH, November 25th. 1919, 1
(Month) (Day) (Year)

7-AGE, 1 yrs. ---- mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 0 0
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James Gales.(C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mamie Norfolk.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Gales.(C)mother.

(Address) 37 Guilford Alley.

15- Filed NOV 29 1920, 191.... Robert P. Harrison, JOHNS Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Eenhard M. D. (Coroner.)

Nov. 29, 191... (Address) 1013 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL.	....., 19...
20-UNDERTAKER Commissioner Health,	ADDRESS NOV 29 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

361

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48512 D.48512 X 37 D.48512

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marybelle Nichols

(Residence in Baltimore: No. Nursery & Child's Hospital St.; ..... yrs., 5 mos. 11 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, C.C.F. ..... (Month) 19 ..... (Day) 1919 (Year)

7-AGE, 1 yrs. 1 mos. 8 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Cambridge Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), ✓

12-MAIDEN NAME OF MOTHER Minnie Nicholas

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, JOHNS HOPKINS HOSPITAL

NOV 19 1920 ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 27 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to Nov 17, 1920, that I saw h~~e~~ alive on Nov. 17, 1920, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

..... (Duration) 1 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Gangrene of Extremities

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. J. Feinglass M. D.

Nov. 29, 1920 (Address) 200 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 5 mos. 11 ds. In the State 1 yrs. 1 mos. 8 ds.

Where was disease contracted, if not at place of death? Cambridge Md.

Former or usual residence Cambridge Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	....., 191...
20-UNDERTAKER	ADDRESS NOV 29 1920
Commissioner Health.	

Per Wm E. WOODALL

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48513

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48513

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Swann

(a) RESIDENCE. No. 1212 N. Stricker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Swann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) Robert M. T. Harrison,

15 Filed NOV 28 1920, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Nov. 26, 1920, that I last saw him alive on Nov. 26, 1920, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. (History) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Kligrey, M. D.

11-26-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 29 1920, 19
20 UNDERTAKER Commissioner Health, Per. Wm. E. WOODALL	ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

D. 48514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48514

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 E. Cross St. 24 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Parents) Julian H. & Barbara Cox

(Residence in Baltimore: No. 138 E. Cross St. yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	White	Mar

6-DATE OF BIRTH, 11 (Month) 27 (Day), 1920 (Year)

7-AGE, 2 yrs. 2 mos. 3 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Julian H Cox

11-BIRTHPLACE OF FATHER (State or Country), Essex Co Va

12-MAIDEN NAME OF MOTHER Barbara E. Curran

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barbara Cox

(Address) 138 E. Cross St.

15- NOV 29 1920 Robert P. Harrison, Registrar.
Filed ..... 191.....
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 27 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11.27 1920, to 11.27 1920, that I saw h.. alive on 11.27 1920, and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows:

Prematur Birth.

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pleuro Pneumonia

..... (Duration) ...yrs. 6 mos. ...ds.

(Signed) L. J. Turlington M. D.

11.29., 191.. (Address) 1652 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL. ..... 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health. NOV 29 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48515 + 63

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda Henderson

(a) RESIDENCE. NO. Smithfield W. Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Louis Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country) 2.

12 MAIDEN NAME OF MOTHER Eliza Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) J H Hospital Records

15 Filed NOV 29 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Nov 29, 1920, that I last saw her alive on Nov. 29, 1920, and that death occurred, on the date stated above, at 2.32 a.m.

The CAUSE OF DEATH* was as follows:

Tumor of Spinal Cord

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) D. R. Mason M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sistersville W. Va	Nov. 29 1920
20 UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.48516 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48516

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Carroll ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Flanagan

(a) RESIDENCE. No. 1109 Carroll ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John Flanagan

6 DATE OF BIRTH (month, day, and year) Jan 2 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Flynne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Conlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Flanagan
(Address) 1109 Carroll St

15 Filed NOV 29 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Nov 27, 1920, that I last saw her alive on Nov 26, 1920, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Hoag, M. D.

11/28 1920 (Address) 712 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 11/30 19 20

20 UNDERTAKER: J. G. Doran — ADDRESS: 3000 E. Baltimore St

—M. & T.—2000 Bks.

20.48517

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.4851

CERTIFICATE OF DEATH.

46

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2709 Guilford Ave St.; 12 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Porter Sherwood

(Residence in Baltimore: No. 2709 Guilford Ave St.; 72 yrs., 3 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 7, 1848 (Month) (Day) (Year)

7-AGE, 72 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer-030
(b) General nature of industry, business, or establishment in which employed (or employer) Marine

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Sherwood

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Eliza Hunter

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Sherwood

(Address) 2709 Guilford Ave

15- Filed NOV 29 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1920, to Nov. 27 1920, that I saw h[illegible] alive on Nov. 26 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Infected Prostate

Duration (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. B. Butler M. D.

Nov 28, 1920 (Address) 1711 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, 11/30, 191..

20-UNDERTAKER J. A. Moran ADDRESS 3000 E Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Probably Carcinoma of Prostate

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneu- qualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion.	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—R. P. Co.—1000 Bks.

20.485-18

HEALTH DEPARTMENT—CITY OF BALTIMORE

50

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Crew (Mary Elizabeth Crew)

(a) RESIDENCE. NO. 729 N. Fremont Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George R. Crew

6 DATE OF BIRTH (month, day, and year) July 24 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 637
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg
(State or country) West Va.

PARENTS

10 NAME OF FATHER Christian Andrae

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Eisenberg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Charles Andrae
(Address) 729 N. Fremont Ave.

15 Filed 29 1920 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/27, 1920, to 11/28, 1920, that I last saw h— alive on 11/28, 1920, and that death occurred, on the date stated above, at 5. PM. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma A. Rodiek, M. D.

11/28 1920 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov-30 1920

20 UNDERTAKER ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

2048519 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048519

CERTIFICATE OF DEATH.

99

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 535 N. Decker Av. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotta Goecke

(a) RESIDENCE. No. 535 N. Decker Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Louis Goecke

6 DATE OF BIRTH (month, day, and year) July 3/50

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Horner

(Address) 535 N. Decker Ave

15 Filed NOV 30 1920 ROBERT E. LAUCHLI

Burial Permit Clerk

N. B.—WRITE ... should be carefully ... mation should be ... CAUSE OF DEATH in plain terms so that ... TION ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17

I HEREBY CERTIFY, That I attended deceased from 11/24 1920, to 11/27 1920, that I last saw h w alive on 11/27 1920, and that death occurred, on the date stated above, at 12 55 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Franz M. D.

19 N 1920 (Address) 1939 Mc Elderry St M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Nov. 30 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048520 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Betzie L. Jacobs

(a) RESIDENCE. No. 1249 Orleans St. Lt. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Jacobs

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	Do not know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Betzie Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Phillip Jacobs

(Address) 1249 Orleans St.

15 Date NOV 30 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-18- 1920, to 11-29 1920, that I last saw h[illegible] alive on 11-29 1920, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Multiple Metastasis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-22-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Ulrich Craig M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 11/30 1920

20 UNDERTAKER Isaac Lewis

ADDRESS 1411 E. Baltimore

N. B. [illegible] mation should be entered [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

144629 D48521 — D48521 — X 37-092

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Appman

(a) RESIDENCE. NO. San Antonio Texas ST., WARD San Antonio Texas
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Geo Appman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Ernestine Boerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J H Hospital Records
(Address)

15 Filed NOV 30 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY. Ink should be used. AGE should be carefully supplied. All information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Nov 29, 1920, that I last saw h in alive on Nov 29 - , 1920, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Fever.
Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Fever.

(duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? San

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? — Autopsy

(Signed) H. H. Bailey, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
San Antonia Texas	Nov 30 1920
20 UNDERTAKER	ADDRESS
Joseph Adrens	221 N Bal

Spec.—6-9-19—H. P. Co.—1000 Blks.

Butler

HEALTH DEPARTMENT—CITY OF BALTIMORE

Hinkley & Old Fd. Rd + Forrich.

1948522 79 1948522

CERTIFICATE OF DEATH.

1948522

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 E 25th St - ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia L. Entler

(a) RESIDENCE. NO. 1649 E 25th St - ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John P. Entler

6 DATE OF BIRTH (month, day, and year) Jan 27 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John P. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Sarah Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Wm A Entler (Address) 1649 E - 25th St

15 Filed NOV 30 1920 ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1920

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1920, to Nov 27, 1920, that I last saw her alive on Nov 26, 1920, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) A. L. Kinzer M. D.

11/28, 1920 (Address) 2700 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shipherdstown W Va — DATE OF BURIAL Dec 1 19

20 UNDERTAKER Wm Carter — ADDRESS A + G Mkt

N. B.—Information should be carefully supplied, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048523 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048523

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1601 N. Port ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie A Rohlfing

(a) RESIDENCE. NO. 1531 N. Port ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. F. Rohlfing

6 DATE OF BIRTH (month, day, and year) Nov 14, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	-	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William L Downey

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Owens

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Charles F Rohlfing

(Address) 1601 N. Port st

15 NOV 30 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1920, to Nov. 28, 1920.

that I last saw h alive on Nov. 28, 1920.

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? Clinical Lab -

(Signed) A C Fuhrmeister M.D. M. D.

11/29/20 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 1 1920
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

N. B.—WRITE should be carefully supplied. Abbreviations should be avoided, so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48524 HEALTH DEPARTMENT—CITY OF BALTIMORE D48524

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1212 Wilcox ST. 10 WARD)

2-FULL NAME Mary. E. Knighton

(a) RESIDENCE. NO. 1212 Wilcox ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Octob 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER John A. Knighton

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Mannion

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mr John A. Knighton
(Address) 1212 Wilcox St

15 Filed NOV 30 1920 19 ROBERT J. TRAUTEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/27, 1920, to 11/30, 1920, that I last saw her alive on 11/29, 1920, and that death occurred, on the date stated above, at 2 20 9, m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Weiss, M. D.

19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 1st 1920
20 UNDERTAKER Henry Hradesky	ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY. All information should be carefully supplied. Answer every question so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0485 25 HEALTH DEPARTMENT—CITY OF BALTIMORE 0485 25

CERTIFICATE OF DEATH.

67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 E. Chase ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Hubbel

(a) RESIDENCE. NO. 1310 E. Chase ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 3 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Bunce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng land

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. C. M. Pepper

(Address) 1310 E. Chase St

15 Filed NOV 30 1920 ROBERT P. BRAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1911, to Nov 28 1920, that I last saw her alive on Nov 28 1920, and that death occurred, on the date stated above, at 1 45 A. m.

The CAUSE OF DEATH* was as follows: Paresis over

(duration) 9 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Bad Kidneys only several y[illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Bull Duval, M. D.

. 19 (Address) 2432 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 2 1920
20 UNDERTAKER	ADDRESS
Henry Houck & Son	1306 E. Eager St

N. B.—WRITE ... should be carefully supplied. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948526 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948526

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 N. Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Parisier

(a) RESIDENCE. No. 1030 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? 33 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Oscar Lippfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) J. Parisier 1030 N. Broadway

15 NOV 30 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Nov. 29, 1920, that I last saw h.. alive on November 29, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolmon, M. D.

Nov 30 1920 (Address) 2444 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Henry Rem	Nov. 30 1920
20 UNDERTAKER	ADDRESS 1121 E. Balto St
May Levinson	

N. B.—BURIAL PERMIT should be carefully supplied. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D48527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48527

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1058 S. 5th St. ST.: Brooklyn 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanna Hammond

(a) RESIDENCE. No. 1058 5th ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A. Hammond

6 DATE OF BIRTH (month, day, and year) June 4, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Landon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) J. M. Ing 1058 S. 5th St

15 Filed NOV 30 1920 ROBERT B. IRWIN Burial Permit Clerk

N. B.—Information should be carefully supplied, so that it may be entered in plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Nov. 27, 1920, that I last saw h[illegible] alive on Nov. 27, 1920, and that death occurred, on the date stated above, at 1145P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) old age

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. Russell Hyf, M. D.

, 19 (Address) 1340 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem., Md	Nov 30 1920
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1711 Eight St

Spec.—8-24-14—M. & T.—2000 Bks.

D48528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48528

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 794 W. Franklin ST.; 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Coulson

(Residence in Baltimore: No. 794 W. Franklin St.: 38 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1882 (Year)

7-AGE 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Box factory

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Joseph Coulson

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Laura J. Sibley

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Coulson

(Address) 794 W Franklin St

15-

NOV 30 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov. 24, 1920, that I saw him alive on Nov 24 1920, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) S. Hughes M. D.

Nov. 29, 1920 (Address) 1413 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL W. M. Curtis & Son DATE OF BURIAL Nov 30 1920

20-UNDERTAKER Samuel Hensley ADDRESS 1113 Biddle

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

D48529 HEALTH DEPARTMENT—CITY OF BALTIMORE D48529

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1613 n Part St. ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Christopher.

(Residence in Baltimore: No. 1613 n Part St, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby,

6-DATE OF BIRTH, June 12, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Edward Christopher

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ann Convey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E J Christopher

(Address) 1613 n Part St

15-

Filed NOV 30 1920, 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Hart Ensley M.D.
(Coroner)

11-29-, 191.. (Address) 4 E Oaks

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenly

DATE OF BURIAL, Dec 2, 1920

20-UNDERTAKER Robt F Turner Jr

ADDRESS 1412 N Pine

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Causes of death which may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48530 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48530

63-04

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 19 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Murphy

(a) RESIDENCE. No. 2221 Essex St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 (Single) ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Murphy

6 DATE OF BIRTH (month, day, and year): Nov 25 1866

7 AGE: Years 54; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Henry Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Anna Murphy

(Address): 2221 Essex St

15 Date: NOV 30 1920

Burial Permit Oct 1

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1920, to Nov 27, 1920, that I last saw h... alive on 11-27, 1920, and that death occurred, on the date stated above, at 12:04 A.m.

The CAUSE OF DEATH* was as follows:

Primary - Bulbar apoplexy

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Labar Pneumonia Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Z. V. Hooper, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: Nov 29 1920

20 UNDERTAKER: Wendell Dippel Sons — ADDRESS: 826 N

ROBERT P. FOUTCH

...mation shown on back of certificate. • CAUSE OF DEATH in plain terms. ...TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

848531

HEALTH DEPARTMENT—CITY OF BALTIMORE

848531

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5200 Beechwood & Augusta Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laban Wesley Evans

(a) RESIDENCE. NO. Beechwood & Augusta Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence V. Evans

6 DATE OF BIRTH (month, day, and year) March 14, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) John Boyle Packing Company

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Evans

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza A. Prosser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. Florence V. Evans
(Address) 5002 Augusta Ave., Hamilton

15 Filed NOV 30 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 19 19, to Nov 29, 19 20, that I last saw h~~im~~alive on Nov 29, 19 20, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) 1 yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Carcinoma of Larynx

(duration) 1 yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jany 16/20

Was there an autopsy? no

What test confirmed diagnosis? Mucroscopic Examination

(Signed) Morris B. Gross, M. D.

Nov 30 1920 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12/2. 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B. ... mation should be ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48532 HEALTH DEPARTMENT—CITY OF BALTIMORE D48532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 S. First ST.: 26 WARD)

REGISTERED NO. 1920

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Reiter

(a) RESIDENCE. No. 1218 S. First ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Rosie Reiter

6 DATE OF BIRTH (month, day, and year) Dec - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

(c) Name of employer: Nicholis Reiter & Co

9 BIRTHPLACE (city or town) (State or country): York Pa

PARENTS

10 NAME OF FATHER: Joseph Reiter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Baarknecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Reiter
(Address): 3408 Dillon St

15 Filed NOV 30 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 1920, to Nov 28, 1920, that I last saw him alive on Nov 28, 1920, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H B Fillow, M. D.

11/29 1920 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec 1 1920
20 UNDERTAKER: Lilly & Zeile	ADDRESS: 403 S. Wolfe St.

N. B. mation should be carefully ... so that it may ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of ... ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48533 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48533

CERTIFICATE OF DEATH. REGISTERED NO. 502

1-PLACE OF DEATH St. Agnes Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 25 WARD)

2-FULL NAME Mr. Michael Dauber

(a) RESIDENCE. NO. Spring Grove Catons ST., WARD. St Chas. Hall
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Dauber

6 DATE OF BIRTH (month, day, and year) ~~5 8 yrs~~ 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Manager
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Dr. J. P. Way. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Michael Dauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bodrexell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Dauber
(Address) St Charles Hall Catons

15 NOV 30 1920 ROBERT E KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1920

17 I HEREBY CERTIFY, That I attended deceased from 11-22, 1920, to 11-27, 1920, that I last saw him alive on 11-27, 1920, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis & coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) St. Agnes Hospital M. D.
H. McCaffrey M.D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 12-1-1920

20 UNDERTAKER H C Stenning — ADDRESS 617 N Schroeder

N. B.—Information should be carefully written, so that it may be plain terms, so that it may be understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048534 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048534

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1119 Madison Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Watkins

(a) RESIDENCE. No. 1119 Madison Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John H. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria A. Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Maria L. Carter

(Address) 1119 Madison ave

15 NOV 30 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1901, to Nov 28, 1920, that I last saw her alive on Nov 28, 1920, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:-

Chr. Endo Carditis
with Aortic Stenosis

(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden Cardiac Paraly—
—sis (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Robert W. Mifflin, M. D.

, 19 (Address) 1016 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	12/1 1920

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

N. B.—[illegible] mation should be [illegible] CAUSE OF DEATH in plain terms, so that [illegible] TION is very important. See instructions on back of certificates.

D.48535 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48535

CERTIFICATE OF DEATH.

175-003

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Univ Hospital St. 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Naumann

(Residence in Baltimore: No. 1414 Woodall St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Jan 27 (Month) (Day), 1889 (Year)

7-AGE, 31 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Switchman
(b) General nature of industry, business, or establishment in which employed (or employer): P.B. & W. Ry.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, August Naumann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Gabler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Naumann

(Address) 1414 Woodall St

15- Robert P. Harrison,

NOV 30 1920 ....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
R.R. Injuries Crushing

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) T. C. Steele M. D.
(Coroner.)

Nov 29 1920 (Address) 1436 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Dec 1, 1920

20-UNDERTAKER, J Herring & Co — ADDRESS 2008 Orleans.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

0.48536

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.48536

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 512 N. Monroe ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Baby" Richardson

(Residence in Baltimore: No. 512 N. Monroe St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 28 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 1/2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jas. H. Richardson

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Ethel Marie Whittington

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. H. Richardson

(Address) 512 N. Monroe St.

15- Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 30 1920

N.—Every item of information must be given in plain terms, so that CAUSE OF DEATH may be understood. Dates important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28 1920, to Nov 30 1920, that I saw him alive on Nov 29 1920, and that death occurred, on the date stated above, at about 6:30 a. m.

The CAUSE OF DEATH* was as follows:

(Cyanosis Sudden Dur to)

Enterolis Suddenly

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature - 8 months.

(Duration) ....yrs. ....mos. ....ds.

(Signed) M Bowman Wood M. D.

Nov 30, 1920. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec. 1., 1920.
20-UNDERTAKER Jos Jourdenais & Son	ADDRESS 217 S. Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

10 48537 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 48537

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 316 S. Augusta Ave ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herbert Wille Jr

(a) RESIDENCE. No. 2928 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 year			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Wille

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian H. Henfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) John H. Wille 2928 Mosher St

15 Filed NOV 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1920, to Nov 29, 1920, that I last saw h[illegible] alive on Nov 29, 1920, and that death occurred, on the date stated above, at 8. A. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 15 hrs

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Mahoney M. D.

11/29 1920 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 1 1920

20 UNDERTAKER Harry H. Witzke ADDRESS 531 W. Lanv

mation should be given on back of certificate.
CAUSE OF DEATH in plain terms. So that
TION is very important. See instructions on b

Spec.—8-24-14—M. & T.—2000 Blks.

0.48538 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48538

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2689 Hillsdale Av ST.: 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Pole

(Residence in Baltimore: No. 2689 Hillsdale Av St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 5 (Month) 3 (Day) 1839 (Year)

7-AGE, 81 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Wm Pole

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Emily V Stier

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C Pole

(Address) 2689 Hillsdale Av

15- NOV 30 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

N. B.—Everything must be written in plain terms. CAUSE OF DEATH in plain terms. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 28 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920, to Nov. 28 1920, that I saw him alive on Nov. 28 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Complication Resp. Trouble

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) A. C. Pole M. D.

Nov 28, 1920. (Address) 2034 Madison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Dec 1, 1920

20-UNDERTAKER Harry H. Weitzle

ADDRESS 1531 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048539

2048539

CERTIFICATE OF DEATH.

92-089

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 S. Bethel ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Burrows Ra

(Residence in Baltimore: No. 801 S. Bethel St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Wdw

6-DATE OF BIRTH, September (Month) 8 (Day), 1851 (Year)

7-AGE, 69 yrs. 2 mos. 20 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Stephen Wadeeki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Agnes

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Burrows Ra

(Address) 801 S. Bethel St.

15- ROBERT B KRAUTER

Registrar. DEC 1 - 1920 Burial Permit Issued.

N.B.—Every item of DEATH in plain terms. CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 22 1920, to November 28 1920, that I saw h[illegible] alive on November 28 1920, and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 14 ds.

(Signed) L. Swindell M.D.

11-29-, 1920. (Address) 722 S. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary | DATE OF BURIAL, Dec 1, 1920

20-UNDERTAKER William Fallowfield | ADDRESS 1st Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 48540

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 48540

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 N Appleton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Elizabeth Miller

(Residence in Baltimore: No. 1540 N Appleton St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) ..., 1875 (Year)

7-AGE, 45 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Thomas H Folson

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Virginia Earhart

13-BIRTHPLACE OF MOTHER (State or Country). Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent J Miller

(Address) 1540 N Appleton St

15- ROBERT B KRAUTER DEC 1 - 1920

Filed ... 19... Registrar.

N. B.—Every item of DEATH in plain terms. CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1920, to Nov 30 1920, that I saw h[illegible] alive on Nov 30 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. 8 ds.

(Signed) J. M. Thompson M. D.

Dec 1, 1920 (Address) 836 S. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, 12/4, 1920

20-UNDERTAKER Martin Fahey Son

ADDRESS 1827 N. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 48541

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 48544

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N. Gilmor ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Lindenberger.

(Residence in Baltimore: No. 419 N. Gilmor St.) Life ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1848 (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): OH!

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Augustus Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah Jackson

(Address) 419 N. Gilmor St.

15 DEC 1 - 1920 Filed....., 191.... ROBERT E KRAUTER Registrar

Burial Permit Given

N.B.—Every item of CAUSE OF DEATH in plain terms, as important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1920, to Nov. 28 1920, that I saw her alive on Nov. 28 1920, and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hemorrhoids,
2nd Attack since Oct. 22-20.
(Duration) - yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. McCardell M. D.

Nov. ....., 191... (Address) 906 N. Mitchell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec. 1, 1920

20-UNDERTAKER Frederick Smedley ADDRESS 1518 Druid Hill Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48542 HEALTH DEPARTMENT—CITY OF BALTIMORE D48542

CERTIFICATE OF DEATH.

8-04

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Patapsco Westport St. 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margorie May Carrick

(a) RESIDENCE. No. 104 Patapsco Westport St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Carrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co.

12 MAIDEN NAME OF MOTHER Emma Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Mrs Daniel Carrick
(Address) 104 Patapsco St.

15 Filed DEC 1 - 1920 19 ROBERT E KRAUSE Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Nov 30, 1920, that I last saw her alive on Nov 29, 1920, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Whooping cough.

(duration) no yrs. no mos. 26 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) no yrs. no mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Raymond S. Glenn, M. D.

, 19 (Address) Sykesville,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 1 1920
20 UNDERTAKER	ADDRESS
A. Sander & Son	1710 Fort St.

mation should be given in plain terms. CAUSE OF DEATH in plain terms. TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

2 48543

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 48543

CERTIFICATE OF DEATH.

1879

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 E. Lombard ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Oestreich

(a) RESIDENCE. No. 1143 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Oestreich

6 DATE OF BIRTH (month, day, and year) Sept 29 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Cabinet

(c) Name of employer Maker.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Otto Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hemmerick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Oestreich
(Address) 1143 E Lombard St

15 Filed DEC 1 - 1920 ROBERT B KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920 to Nov. 29 1920, that I last saw h.. alive on Nov. 29 1920, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William Francis, M. D.

, 19 (Address) 1407 Mar

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 1 1920
20 UNDERTAKER	ADDRESS
H Sander & Son	1710 Pleet St.

...mation should be ... in plain terms, so ...
CAUSE OF DEATH ...
TION is very important. ... Instructions

D48544 HEALTH DEPARTMENT—CITY OF BALTIMORE. 45 D48544

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 916 Watson Street ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Lane

(Residence in Baltimore: No. 916 Watson Street St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... November ....., 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Furrier
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Lane

11-BIRTHPLACE OF FATHER (State or Country), Hessia

12-MAIDEN NAME OF MOTHER Unken

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levi

(Address) 1411 E Balto St

15-

Filed DEC 1 — 1920, 191.... ROBERT A. KRANTZ Registrar.

Burial Permit Sent

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spleen

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas P. Smith M. D.
Dec 1, 1920 Coroner. (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Pikesville — DATE OF BURIAL, Dec 1, 1920

20-UNDERTAKER Jacob Levi — ADDRESS 1411 E Balto

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 48545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48545

CERTIFICATE OF DEATH. A 102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Bal to Eu Hosp ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Elwood Gibson

(a) RESIDENCE. No. Rock Hall, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Oct 10. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician & Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer Tolchester Co..

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER John H. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Annie Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware.

14 Informant Harry Gibson (Address) Rock Hall. Md

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1920, to Nov. 30, 1920, that I last saw him alive on Nov. 30, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows: Ulcer of Stomach (Large penetrating ulcer of lesser Curvature) Sore.

CONTRIBUTORY (Secondary) Surgical shock and perforation of stomach (duration) 3 yrs. — mos. — ds. (duration) — yrs. — mos. 18 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Johnson, M. D.

. 19 (Address) So Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md via Tolchester — DATE OF BURIAL Dec 1 1920

20 UNDERTAKER John F Denny — ADDRESS 115 Eight

N. B.—mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

pec.—6-9-19—H. P. Co.—1000 Bks.

D48546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48546

CERTIFICATE OF DEATH

1-PLACE OF DEATH Boyview Hospital

REGISTERED NO. 91

CITY OF BALTIMORE: (No. ..... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate King

(a) RESIDENCE. NO. 5712 W. Hoffman ST.. ..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Boyview Hosp. (Address) Balto, Md.

15 Filed DEC 1 - 1920, 19 ROBERT B. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30. 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1920, to Nov. 30, 1920, that I last saw h[illegible] alive on Nov. 29, 1920, and that death occurred, on the date stated above, at 7.57 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Dementia & Decubitus (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Gradsmith, M. D.

11/30/1920 (Address) Boyview Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 2 1920
20 UNDERTAKER	ADDRESS
David Easton	Fair

mation should be given in plain terms. So that a CAUSE OF DEATH in plain terms, so that a TION is very important. See instructions on back of certificate.

Spec.—5-8-19—H. P. Co.—1000 Bks.

D 48547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48547

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Josephs Hosp ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Lemmerher

(a) RESIDENCE. No. 3428 Park Heights Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm F. Lemmerher

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Irma a Doerr

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Wm F Lemmerher
(Address) 2631 Calvert St

15 Filed DEC 1 - 1920 ROBERT A KRAUSE Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any mistake may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Nov 30, 1920,

that I last saw him alive on Nov 29, 1920

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy exam

(Signed) Wm F Lemmerher, M. D.

, 19 (Address) 2631 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 1 1920
20 UNDERTAKER	ADDRESS
W M Routson	2311 N Gren

Spec.—8-24-14—M. & T.—2000 Eks.

D148548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D148548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Haffan St. ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno- Michaelis

(Residence in Baltimore: No. 2625 Haffen St St.: 1 yrs., 2 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. Sept 17, 1919 (Month) (Day) (Year)

7-AGE. 1 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Chas L. Michaelis

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER. Ellen Hardy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas L. Michaelis

(Address) 2625 Haffen St

15-

Filed....., 191.....

ROBERT B KRAUTER
Burial Permit Clerk
Registrar.

DEC 1 - 1920

CAUSE OF DEATH must be plainly written. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov-28 1920, to Nov-29 1920, that I saw him alive on Nov-28- 1920, and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Wrakness Convulsions

(Duration).....yrs.....mos.....1.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) C. L. Nuetzels M. D.

Nov 29, 191... (Address) 130 S. Grayson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 1, 1920.

UNDERTAKER F B Kuppuh

ADDRESS 2236 Frank

Spec.—6-6-19—H. P. Co.—1000 Bks.

D48549 HEALTH DEPARTMENT—CITY OF BALTIMORE 1042 D48549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. Duncan ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Bitter

(a) RESIDENCE. No. 1894 N. Duncan ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced (write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19-1920

7 AGE: Years | Months: 9 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Bitter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes Campell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant August Bitter (Address) 1814 N. Duncan St

15 Filed DEC 1 - 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Nov 29, 1920, that I last saw her alive on Nov 29, 1920, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Consumption

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Thad T Koerner M. D.

Nov 30 1920 (Address) 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 2nd 1920
20 UNDERTAKER	ADDRESS
Chas C Miller	2334 Jefferson

CAUSE OF DEATH in plain terms. ... on back of certificate. TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48550 ✓ 79 D 48550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 W. Preston St.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Murdock

(Residence in Baltimore: No. 538 W. Preston St.; St.: 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. 31, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. 2 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Richard Pryor

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Fannie Pryor

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Murdock (husband)

(Address) 538 W. Preston St.

15-

Filed....., 191. ROBERT B. KRAUTER

DEC 1 - 1920 Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. Please answer all questions. Be particular and exact. Spell all names in full. Do not abbreviate. Use ink. Every question must be answered, or the certificate will be returned for correction. Numbers refer to corresponding numbers on certificate. Read carefully the instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1920, to Nov 29 1920, that I saw her alive on Nov 28 1920, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Fermentative Dyspepsia

..... (Duration) ..... yrs. ..... mos. 2d. ..... ds.

CONTRIBUTORY (Secondary) Cyanosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hutchinson M. D.

Nov 30 1920 (Address) 1203 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Dec. 2, 1920

20-UNDERTAKER J. O. M. Johnson — ADDRESS 1234 Ethan St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48551

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 S. Potomac ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Fuentealba

(a) RESIDENCE. NO. 709 S. Potomac ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 13 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Manuel Fuentealba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chile

12 MAIDEN NAME OF MOTHER Antonette Engler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Manuel Fuentealba 709 S. Potomac

15 Filed DEC 1 - 1920 19 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Nov 30, 1920, that I last saw h.r alive on Nov 30, 1920, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Laryngel Diphtheria

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Intubation nov 30/20 Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. J. McAvoy, M. D.

Dec 1, 1920 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/1 1920
20 UNDERTAKER J. J. Moran	ADDRESS E. Balto

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048552

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048552

87

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST.: 6 WARD)

2-FULL NAME John Carrington

(a) RESIDENCE. NO. N 00 East Fairmount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ Barber

(b) General nature of Industry, business, or establishment in which employed (or employer) Barber 004

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Carrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jennie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Peter Proctor

(Address) 1442 Eutaw Ave

15 Filed DEC 1 - 1920 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/29, 1920, to 11/29, 1920, that I last saw h— alive on 11/29, 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Uremic Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Embolism

(duration) yrs. mos. 5 days.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Irwin D. Ridgely M. D.

11/29 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Dec 1 1920
20 UNDERTAKER	ADDRESS 1728
Mrs R A Elliott	Ashland Ave

CAUSE OF DEATH in plain terms. [illegible] on back of certificate. TION is very important. See instructions on back.

Spec. 6-9-19 H. P. Co. 1000 Blks.

1048553 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048553

CERTIFICATE OF DEATH. 34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levan Thomas

(a) RESIDENCE. No. 511 Watson St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	if LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Isreal Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Margaret Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records,

(Address) New City Hospital. ~~ROBERT E KNOTTS~~

DEC 1 - 1920 ~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 23, 1920 to November 28 1920, that I last saw him alive on November 28, 1920, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

T. B. of ankle (right)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneum- and (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? not as yet.

What test confirmed diagnosis? X ray.

(Signed) H Holden, M. D.

11/28/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 1 1920
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 725 Ashland Ave

CAUSE OF DEATH in plain terms. ... certificates.
TION is very important. See instructions on back of cer...

Spec.—6-9-19—H. P. Co.—1000 Blks.

0148554 HEALTH DEPARTMENT—CITY OF BALTIMORE 0148554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glen Ave. near Belair Road ST.: Rasteburg 91 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Waldman

(a) RESIDENCE. No. Glen Ave near Belair Road ST.: Rasteburg WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31st 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER W. Eugene Waldman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie J. Shilling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant W. Eugene Waldman
(Address) Rasteburg Ind

15 Filed DEC 1 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30th 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Nov 29, 1920, that I last saw h[illegible] alive on Nov 29, 19..., and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) [signature] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae Cemetery	Dec. 2 1920
20 UNDERTAKER	ADDRESS
Frank Lascalzo Sons	Fullerton Md

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48555 HEALTH DEPARTMENT—CITY OF BALTIMORE D48555

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Hollins St. ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Burman

(a) RESIDENCE. NO. 1135 Hollins St. ST. 18 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Burman

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George Giffin

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D. C.

12 MAIDEN NAME OF MOTHER Mary Ann Bentley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant George L. Burman (Address) 1135 Hollins St.

15 DEC 1 - 1920 ROBERT F KRAUTER Burial Permit Officer Registrar

CAUSE OF DEATH in plain terms, avoiding use of abbreviations or terms on back of certificate. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 27 , 19 , to Nov 29 , 19 20 ,

that I last saw her alive on Nov 29 , 19 20 ,

and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Asthenia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) E. L. Burman, M. D.

11/30, 1920 (Address) 1302 N Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Dec 2nd 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48556 HEALTH DEPARTMENT—CITY OF BALTIMORE D48556

CERTIFICATE OF DEATH.

REGISTERED NO. 15-79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 N. Fulton Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Ellis

(a) RESIDENCE. No. 1325 N. Fulton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Ellis

6 DATE OF BIRTH (month, day, and year) June 27, 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Ellis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U.S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Mrs. John L. Geas
(Address) 1325 N. Fulton Ave.

DEC 1 - 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Nov. 28, 1920, that I last saw him alive on Nov. 28, 1920, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation, Aortic Stenosis & Cardiac Dilatation

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? "Usual Clinical"

(Signed) Thomas J. Talbott, M. D.

, 19 (Address) Marlborough Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 1st, 1920
20 UNDERTAKER Joseph L. Cook	ADDRESS 1003 W. Baltimore St

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificate.

D 48557 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1735 Hollins St.: 19 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Wilson

(Residence in Baltimore: No. 1735 Hollins St.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Sept (Month) 19 (Day), 1861 (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 2 mos. 10 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Luther Mercier

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Esther Burgess

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Lott R. Wilson

(Address) 1735 Hollins St.

15- Filed DEC 1 - 1920, 191. ROBERT I KRAUTER Burial Permit Clerk. Registrar.

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to. the death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) Sudden yrs. mos. ds.

(Signed) James M Pentlen M. D. (Coroner.)

Nov 29, 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 1735 Hollins

Former or usual residence 1735 Hollins

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Dec 1st, 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

No hemorrhage. Enlarged heart

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gangrene, Gastritis, Erysipelas, Meningitis, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Rec.—6-9-19—H. P. Co.—1000 Bks.

1048858

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048858

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Burns.

(a) RESIDENCE. NO. 1510 William ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 15: 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	054	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Jno. Burns (Address) 1510 William St.

15 Filed DEC 1 - 1920 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1920

17 I HEREBY CERTIFY, That I attended deceased from August, 1920, to Nov 29, 1920.

that I last saw h.. alive on Nov 24, 1920.

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppurative nephritis

duration) 2 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct. 30.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Whitehurst, M. D.

Nov 29, 1920 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Dec. 2 1920

20 UNDERTAKER M. J. Flynn

ADDRESS 1425 Light St.

CAUSE OF DEATH must be stated plainly. See instructions on back. TION is very important.

Sec.—6-9-19—H. P. Co.—1000 Bks.

2048559

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048559

61

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2213 Eastern Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nemczyski

(a) RESIDENCE. NO. 2213 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 24, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Nemczyski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kurek

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant John Nemczyski
(Address) 2213 Eastern Ave

15 Filed ..... 19 ROBERT I. KRAUTER Registrar
DEC 1 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 — 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Nov — 30, 1920, that I last saw h— alive on Nov 30, 1920, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows: over

Meningitis —

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebro Spinal

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Bramwell, M. D.

(Address) 8 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 2 1920

20 UNDERTAKER John M Archer ADDRESS 1803 Bank

MEDICAL CERTIFICATE OF DEATH in plain letters. CAUSE OF DEATH must be stated. See instructions on back of certificate. TION is very important.

Caroline L. Cannon 1048560

Spec.—8-24-18—M. & T.—2000 Blks.

1048560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 2492

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 E. Barney ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline L. Cannon

(Residence in Baltimore: No. 503 E. Barney St.; 35 yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 14, 1885
(Month) (Day) (Year)

7-AGE, 35 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas Young

11-BIRTHPLACE OF FATHER (State or Country), Boston, Mass.

12-MAIDEN NAME OF MOTHER Louise Kuhlmeyer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Young

(Address) 1122 Eyrodale

15- ROBERT B KRAUTER

Filed DEC 1 1920 191.... Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1920, to Nov. 30 1920, that I saw her alive on Nov. 30 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

.....

.....

..... (Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration)....yrs. 1 mos. 6 ds.

(Signed) L. Blumenau M. D.

12/6/20 (Address) 1 E. Penn ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, 12/3, 1920

20-UNDERTAKER S. Frew McCully

ADDRESS 130 E. Fort ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

L948561 HEALTH DEPARTMENT—CITY OF BALTIMORE L948561

CERTIFICATE OF DEATH. X 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 78th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes R. McMillan

(a) RESIDENCE. NO. Westernport Md ST., WARD. (Westernport-Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? 69 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married-

5a If married, widowed, or divorced (or) WIFE of Mrs R. M. McMillan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country) Penna-

PARENTS

10 NAME OF FATHER Phillip Galon

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Lonsa

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country) Penna

14 Informant (Address) Records of Mt Hope Retreat Baltimore Md-

Filed DEC 1 - 1920 ROBERT I. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30. 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1920, to Nov. 30., 1920, that I last saw her alive on Nov 30., 1920, and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Dementia (duration) 0 yrs. 11 mos. 0 ds.

18 Where was disease contracted if not at place of death? Westernport Md

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Westernport Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — DATE OF BURIAL 108 W. NORTH AVE. ADDRESS

20 UNDERTAKER Piedmont- W. Va. Dec-1-1920

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

D.48562 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48562

CERTIFICATE OF DEATH.

155

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME E. Gordon Cook

(Residence in Baltimore: No. 616 Crawford St.; yrs., 19 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Dec. (Month) 14, (Day) 1900 (Year)

7-AGE, 19 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer): (Building)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry E. Cook

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Emma M. Pritchard

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mildred V. Cook

(Address) 616 Crawford St.

15- DEC 1 - 1920 Robert P. Harrison, Registrar.
Burial Permit Clerk.

N. B.—Every item in CAUSE OF DEATH in plain terms, as important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by carbolic acid, (1½ hr.)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 1 1920 (Address) 807 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? (On street)

Former or usual residence 616 Crawford St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto County	Dec 3, 1920

20-UNDERTAKER	ADDRESS
Robt J Barber Sons	1442 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

20.48563

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... St.; 17 WARD)

REGISTERED No. C 126

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E Physioc.

(Residence in Baltimore: No. 306 E. 25th St. St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH January (Month) 16 (Day), 1836 (Year)

7-AGE. 84 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country). Beaufort. North Carolina

PARENTS.

10-NAME OF FATHER. Wm. Physioc,

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Martha Johnson,

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert C. Physioc

(Address) 306 East 25th St.

15-

Filed DEC 1 - 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Dec 1 1920, that I saw him alive on Dec 1 1920, and that death occurred, on the date stated above, at 5.55 a.m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis with hypertrophy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertrophy prostate with obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas R. Goldborough M. D.

12/1, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Not known.

Former or usual residence 306 E 25th St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Dec. 3. 1920

20-UNDERTAKER	ADDRESS
Geo W Little	531 N. Fremont Ave

CAUSE OF DEATH must be stated in every case. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48564 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48564

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 St Paul ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa M. Behn

(a) RESIDENCE. NO. 2527 St. Paul ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. J. Behn

6 DATE OF BIRTH (month, day, and year) Nov 5. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	0	24	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto City. Md

PARENTS

10 NAME OF FATHER Charles J. Holbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Remscheidt- Germany

12 MAIDEN NAME OF MOTHER Eleanora Pietsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Darmstadt- Germany.

14 Informant Charles J. Behn

(Address) 2527 St. Paul pl.

15 Filed DEC 1- 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 29th Nov. 1920

17 I HEREBY CERTIFY, That I attended deceased from for years, 19....., to ....., 19....., that I last saw her alive on Nov 29- 1920, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis senile (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. C. DeLyon, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Dec 2 1920

20 UNDERTAKER Wm J. Ecker Sons

ADDRESS North & Pa

CAUSE OF DEATH to be plainly written. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

MARIE BURESCH

0.48565 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.48565

CERTIFICATE OF DEATH. 28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 E Chase ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mama Buresch (Buresch)

(Residence in Baltimore: No. 1916 E Chase St.; 17 yrs., ... mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1903 (Year)

7-AGE, 17 yrs. 14 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Buresch

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Rose Lang

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Buresch

(Address) 1916 E Chase St

15- DEC 1 1920 Robert P. Harrison, Registrar. 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Nov 29 1920, that I saw h[illegible] alive on November 29 1920, and that death occurred, on the date stated above, at 11.45A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs

Aug 12 Chronic Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs

(Duration) yrs. 3 mos. 24 ds.

(Signed) J. Talmage Simms M. D.

Nov. 30th, 1920. (Address) 1925 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Dec 3, 1920
20-UNDERTAKER Frank Creech Son	ADDRESS 1918 Eastlander

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.48566

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.48566

79-010

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Aisquith ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Quigley

(a) RESIDENCE. No. 1621 Aisquith ST., WARD.

(Usual place of abode) Lifetime (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Quigley.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant -Bernard J. Quigley

(Address) 1621 Aisquithh St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

DEC 1 - 1920 Burial Permit Clerk.

CAUSE OF DEATH IN plain ... TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1918, to Dec. 1, 1920, that I last saw h... alive on Dec. 20, 1920, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death? yes

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Bunton M. D.

12-1, 19 20 (Address) 1512 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec 4 1920

20 UNDERTAKER Chas F. Ward & Son ADDRESS 1180 Nd. Royal Ave

D.48567 HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 16 WARD) 175-001 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. A. Holcamp.

(Residence in Baltimore: No. 1207 Lamens St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 6, 1847 (Month) (Day) (Year)

7-AGE, 73 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Kept a D.G. Store
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dry Goods Store.

9-BIRTHPLACE, (State or Country), Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Don't Know.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Don't Know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Holcamp

(Address) 1207 Lamens Street

15- Filed DEC 1 1920, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item in this CERTIFICATE OF DEATH is plain type, so that each is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 29, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Automobile Accident Multiple Fractures

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Wade M. D. (Coroner)

12/2/20, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 3, 1920

20-UNDERTAKER William Cook — ADDRESS 502 E. North Ave

Spec. 6-3-19—H. P. Co.—1000 Bks.

20.48568 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48568

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2935 Huntingdon ave ST.: 17 WARD)

2-FULL NAME Lancelot Nevin Hyle

(a) RESIDENCE. No. 2935 Huntingdon Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 50 ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Denny Hyle

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Nevin

13 BIRTHPLACE OF MOTHER (city or town) Balto. co., Md.
(State or country)

14 Informant Walter Denny Hyle.
(Address) 2935 Huntingdon ave

15 Filed DEC 1 1920 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Dec. 1, 1920, that I last saw him alive on Nov. 29, 1920, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Maurice L. Shamer, M. D.

12/1, 1920 (Address) 5300 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Dec 2 1920
20 UNDERTAKER E. LeRoy Stiffler	ADDRESS 1255 North ave

mation should be given in answering these questions. CAUSE OF DEATH in plain terms, so that a person unacquainted with medical terms may understand. See instructions on back of certificates. TION is very important.

cc.—6-9-19—H. P. Cc.—1000 Bks.

0.48569. HEALTH DEPARTMENT—CITY OF BALTIMORE V 0.48569

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 110 Colesspring ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Collins.

(a) RESIDENCE. No. 40 Cold Spring Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hugh Collins

6 DATE OF BIRTH (month, day, and year): May 24-

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): Housemaid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hester Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Patricia Collins
(Address) 40 Colesspring Ave.

15 Filed 19 Robert P. Harrison, Registrar

DEC 1 - 1920

Burial Permit Clerk.

CAUSE OF DEATH. TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 30 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept., 1920, to Nov. 30, 1920, that I last saw h alive on November 2, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

old age

0700

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture of neck of femur

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Boston Or.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Milton P. Hill, M. D.

, 19 (Address) Wylie Ave & Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Dec 3 1920
20 UNDERTAKER	ADDRESS 178
Robert S. Brookerson	Calhoun

Rec.—6-9-19—H. P. Co.—1000 Bks.

048570 HEALTH DEPARTMENT—CITY OF BALTIMORE 048570

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Stirling ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Howard

(a) RESIDENCE. No. 640 Stirling ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Howard

6 DATE OF BIRTH (month, day, and year) March 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Maid

(b) General nature of industry, business, or establishment in which employed (or employer) House Maid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joshua Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Henrietta Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne's

14 Informant Mrs R A Elliott

(Address) 1725 Ashland Av

15 DEC 2 - 1920 ROBERT B. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH. ATION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 19 20, to Nov 30, 19 20, that I last saw h. alive on Nov 29, 19 20, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy - Hemorrhage of Brain - Natural Causes

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Probable Embolic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General State

(Signed) W C Burns, M. D.

(Address) 2218 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Decem 2 1920
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No 48571

CERTIFICATE OF DEATH.

No 48571

1-PLACE OF DEATH: Mercy Hosp.

CITY OF BALTIMORE: (No. 1908 Pleasant Ave ST. 17 WARD)

2-FULL NAME: ~~Mrs Eliz. Miller~~ Elizabeth Miller

(a) RESIDENCE. NO. 1908 Pleasant Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry C. Miller

6 DATE OF BIRTH (month, day, and year) Feby 26th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Spangler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Mary Kirkner 1908 Greenmount ave.

15 Filed DEC 2 - 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH In plain words, do not use abbreviations. See instructions on back of this certificate. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 1, 1920, that I last saw h[illegible] alive on Nov 30 1920, and that death occurred, on the date stated above, at 1.11. A m.

The CAUSE OF DEATH* was as follows:

Uremia — 3 days
H Hypertension. DWH

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile gangrene of 4 toes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Warfield M. D.

, 19 (Address) 1908 Pleasant Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Dec 4th 1920

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 E Monument

Sec.—6-2-19—H. P. Co.—1000 Bks.

2048572

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048572

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Bond ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Bell

(a) RESIDENCE. NO. 526 N. Bond ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of George E Bell

6 DATE OF BIRTH (month, day, and year) July 19th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Stock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Catherine Barnard (Address) 625 N Bond St

15 Filed DEC 2 - 1920 ROBERT R KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH BE PRECISE AND COMPLETE. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1920, to November 30, 1920, that I last saw h alive on Nov 30, 1920, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

C. Apoplexy

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? 525 N Bond

Did an operation precede death? No Date of Nov 30.

Was there an autopsy? No

What test confirmed diagnosis? Diagnosis of Left Side

(Signed) A. Wegeforth, M. D.

, 19 (Address) 1301 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 3rd 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

0485 73 HEALTH DEPARTMENT—CITY OF BALTIMORE 186 0485 73

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Marziglia

(Residence in Baltimore: No. 52 E. 4th St. St. (yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sgl

6-DATE OF BIRTH, Dec 3, 1893
(Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) 140

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unk

11-BIRTHPLACE OF FATHER (State or Country), Unk

12-MAIDEN NAME OF MOTHER Unk

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Tango

(Address) 52 E Hill St

15- ROBERT E KRAUTER

Filed DEC 2 - 1920 191 Burial Permit Clerk
Registrar.

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH must be stated. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupt intestines, accidentally caused by stick of wood when when pulling belt in position

6 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis fair days

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W J Reilly M. D.
(Coroner.)

Dec 1, 1920 (Address) 1057 Bus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 2, 1920
20-UNDERTAKER Geo J Smith	ADDRESS 100 E Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

1048574 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 W. Fayette St.; 20 37 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph M. Landragan

(Residence in Baltimore: No. 2201 W. Fayette St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sep (Month) 18 (Day), 1851 (Year)

7-AGE, 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Non
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Landragan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Moulton

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Landragan

(Address) 2201 W. Fayette St

15- Filed DEC 2 - 1920 ROBERT N KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21st 1920, to Nov. 29th 1920, that I saw h[illegible] alive on Nov. 29th 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pertiary Syphylis

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) Elgene Douglas M. D.

Nov. 30, 1920 (Address) 830 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Dec. 3, 1920
20-UNDERTAKER George J Smith	ADDRESS 1000 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

48575 Wolf. D48575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Broughton St.; 16 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Wolf

(Residence in Baltimore: No. 2906 Broughton St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 3, 1842 (Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nothing
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wolf

11-BIRTHPLACE OF FATHER (State or Country). Don't know

12-MAIDEN NAME OF MOTHER Lankum

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. A. McKinstry

(Address) 2906 Broughton St

15-

Filed ..... 192.....

DEC 2 - 1920

ROBERT E KRAUSE
Registrar.

CAUSE OF DEATH. This line must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1920, to Nov 30 1920, that I saw h[illegible] alive on Nov 29 1920, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration ..... (Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) Chas. A. McKinstry M. D.

12/1/1920 (Address) 2042 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 2, 1920

20-UNDERTAKER Josiah Syfer — ADDRESS 1600 N North Ave

Sec.—6-9-19—H. P. Co.—1000 Blks.

248576 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ 248576

CERTIFICATE OF DEATH.

REGISTERED NO. 1628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Blair

(a) RESIDENCE. No. 1928 N. Fulton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Blair

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Dickerhof

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Amelia ??

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 Filed DEC 2 - 1920 ROBERT I. KRAUTH Registrar
Hospital Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Nov. 30, 1920, that I last saw her alive on Nov. 30, 1920, and that death occurred, on the date stated above, at 9.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum,

(Signed) L. J. Tigrey, M. D.

12-1-20. (Address) Municipal Hosp. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 3rd 1920
20 UNDERTAKER	ADDRESS
Josiah Leyer	600 Park Ave

CAUSE OF DEATH IN DOUBTFUL CASES. See instructions on back. ATTENTION is very important.

1048577 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048577

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 20 175-001 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Spaltz

(Residence in Baltimore: No. 16 N. Bentalou St.; yrs. 59 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widow

6-DATE OF BIRTH, Feb. (Month) 8 (Day), 1861 (Year)

7-AGE, 59 yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Boyd

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Gabel

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Wolf

(Address) 16 N. Bentalou St

15- Filed DEC 2 - 1920, 191 ROBERT E KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Traumatic laceration of liver

(Duration) yrs. mos. 2 ds.

(Signed) C. J. Hennessy M. D. (Coroner.)

Nov. 29, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death Md. Gen. Hosp. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?
Cor. Fremont & Balto. Sts

Former or usual residence 16 N. Bentalou St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Dec. 2, 1920
20-UNDERTAKER Jos. L. Schwab & Bro	ADDRESS 2101 Eutaw Ave

N.B.—Every item of DEATH in plain terms, as that CAUSE OF DEATH is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1048578 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048578

CERTIFICATE OF DEATH. 9 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Bartlett Ave ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Rau

(a) RESIDENCE. NO. 620 Bartlett Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Elizabeth Rau

6 DATE OF BIRTH (month, day, and year) May 24 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer M. P. R. R. Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Rau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Elizabeth Rau 620 Bartlett Ave

15 Filed DEC 2 - 1920 ROBERT B. ARAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1924, to Nov. 30 1920, that I last saw h[illegible] alive on Nov. 30 1920, and that death occurred, on the date stated above, at 7.51 a.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not as Reported

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) H. L. Forsythe, M. D.

, 19 (Address) 524 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Dec. 3 1920

20 UNDERTAKER H. Zander Sons ADDRESS 1210 Park

N. B.—[illegible] should be carefully written in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

2648579 HEALTH DEPARTMENT—CITY OF BALTIMORE 175-2648579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OR BALTIMORE (No. 1 Bond St. Alleans ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane. Nicholini

(Residence in Baltimore: No. 3936 Pratt St. yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 1 Known, 1 (Month) (Day) (Year)

7-AGE, 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 073

9-BIRTHPLACE, (State or Country), State

PARENTS.

10-NAME OF FATHER, Frank Nicholini

11-BIRTHPLACE OF FATHER (State or Country), State

12-MAIDEN NAME OF MOTHER Teresi Rosalia

13-BIRTHPLACE OF MOTHER (State or Country), State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gaetano Rastelly

(Address) 3913 E Pratt St

15- Filed DEC 2 - 1920, 191.. ROBERT E KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Fell by Dropping from Porch

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

191.., (Address) 1 Holly St. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Dec 2 1920

20-UNDERTAKER J Kerney & Co ADDRESS 2008 Aliceanna

N. B.—A CAUSE OF DEATH in plain terms is important. See instructions on back of certificate.

048580 HEALTH DEPARTMENT—CITY OF BALTIMORE 048580

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4837 Parkheights St. 47 WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Frabhund

(Residence in Baltimore: No. 4837 Parkheights St. 47 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH Aug. 24, 1873
(Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066

9-BIRTHPLACE (State or Country) Md

PARENTS.

10-NAME OF FATHER John H. Frabhund

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Emely C. Berghaus

13-BIRTHPLACE OF MOTHER (State or Country) Germany Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. E. Frabhund

(Address) 4837 Parkheights Ave

15- DEC 2 - 1920 ROBERT B BRAUER
Filed....., 191... Burial Permit Issued

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison M. D.
(Coroner.)

Dec 2, 1920 (Address) 432 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Dec. 4, 1920

20-UNDERTAKER John C. Mitchell

ADDRESS 1201 W. Fayette St

Bracato

1048581

Dec.—6-9-19—H. P. Co.—1000 Bks.

1048581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Pearl St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raphael Bracato

(a) RESIDENCE. No. 424 Pearl St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. 8 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	8	

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Bracato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francis Falici

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Bracato

(Address) 424 Pearl St

15 Filed DEC 2 - 1920, 19 ROBERT F. SWEENEY Registrar

Burial Permit Clerk

CAUSE OF DEATH must be plainly stated. See instructions on back of this TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1920, to Dec 2nd, 1920, that I last saw h-m alive on Dec 2, 1920, and that death occurred, on the date stated above, at 2.45a m.

The CAUSE OF DEATH* was as follows:

Non Closure Foramen Ovale

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Gustav Goldman, M. D.

(Signed)

, 19 (Address) 836 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 12/2/20.

20 UNDERTAKER: Harold Easton ADDRESS 916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

48582 HEALTH DEPARTMENT—CITY OF BALTIMORE Maria 48582

CERTIFICATE OF DEATH.

1428

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 McCulloh ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys A. Moses

(Residence in Baltimore: No. 1919 McCulloh St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Dec. (Month) 15 (Day), 1905 (Year)

7-AGE, 14 yrs. 11 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, James H. Mosses

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Mollie J. Bland

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Hall

(Address) 1945 Penna Ave

15- Filed DEC 2 - 1920, 191.. ROBERT E PRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1920, to Nov. 29 1920, that I saw h alive on Nov. 29th 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11-30, 1920. (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec. 2, 1920

20-UNDERTAKER Clement Hall — ADDRESS 1945 Penna Ave

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—8-24-14—M. & T.—2000 Bks.

148583

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 148583

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Park Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J Janney

(Residence in Baltimore: No. 1923 Park Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Jan. 9, 1841 (Month) (Day) (Year)

7-AGE, 79 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sec Treas 086
(b) General nature of industry, business, or establishment in which employed (or employer): House of Reformation

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Henry Janney Jr

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Hannah Seolfield

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. C E Janney

(Address) 1923 Park ave

15-

Filed DEC 2 1920 191 ROBERT E KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16 1920, to Nov. 30 1920, that I saw h im alive on Nov. 30 1920, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. F. Robinson M. D.

Dec. 1, 1920 (Address) 1307 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Friends Cem. DATE OF BURIAL, Dec. 4, 1920

UNDERTAKER Chas. E. Franck ADDRESS 84 Madison Ave

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D48584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48584

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 616 W Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Pratt

(a) RESIDENCE. NO. 616 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonza Pratt

6 DATE OF BIRTH (month, day, and year) Sept 30-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md

12 MAIDEN NAME OF MOTHER Lucretia Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md

14 Informant Thomas Diggs
(Address) 616 Rudolph St

15 Filed DEC 2 - 1920 ROBERT B KRAUSER Registrar Burial Permit Clerk

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1920, to Nov 30, 1920, that I last saw her alive on Nov 27, 1920, and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease Heart

(duration) yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary) Kors Compensation

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) J. L. Stroper, M. D.

11-30, 19 (Address) 346 E 28

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Mt Auburn Cem Dec 3 1920

20 UNDERTAKER Edward L Hensley | ADDRESS 518 N

Eliza M. Parker

Spec.—6-9-19—H. P. Co.—1000 Bks.

0048585 HEALTH DEPARTMENT—CITY OF BALTIMORE 0048585

CERTIFICATE OF DEATH. 172

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1813 E. Fairmount Ave. ST.: 6 WARD)

2-FULL NAME Eliza M. Parker

(a) RESIDENCE. No. 1813 E. Fairmount Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. 7 mos. 28 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word) Widow

5a If married, widowed, or ~~divorced~~ (or) WIFE of Edward L. Parker

6 DATE OF BIRTH (month, day, and year) Apr 5, 1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bakersville Md

PARENTS

10 NAME OF FATHER Solomon Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs. Ida V. Savage 1813 E. Fairmount Ave

15 Filed DEC 2 - 1920 16 ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1920, to Dec 1, 1920, that I last saw her alive on Nov. 25, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Intra-capsular fracture L right femur

over

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) 1 yrs. one mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. symp.

(Signed) G. G. Rinker, M. D.

19 (Address) 201 N. Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Dec 3- 1920

20 UNDERTAKER Wilson & Co ADDRESS 1723 N. Fulton Ave

CAUSE OF DEATH. See instructions on reverse side. ATTENTION is very important.

Rec.—6-9-19—H. P. Co.—1000 Bks.

0485 86 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 79 D48586

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2672 Lehman ST.: 170 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hefner

(a) RESIDENCE. NO. 2672 Lehman ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nicholas Hefner

6 DATE OF BIRTH (month, day, and year) Dec. 1840

7 AGE: Years 79 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs M Maddox
(Address) 2672 Lehman St

15 DEC 2 - 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Nov 30, 1920, that I last saw h[er] alive on Nov 29, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings.

(Signed) H. A. Tuell, M. D.
11/30, 1920 (Address) 4207 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 12/3/20.

20 UNDERTAKER: M Gahey & Son ADDRESS 1811 W Balto.

CAUSE OF DEATH. See instructions on back. INFORMATION is very important.

...et.—6-9-19—H. P. Co.—1000 Bks.

20.48587 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48587

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 S Port ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Morozalkiewicz

(a) RESIDENCE. NO. 717 S. Port ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) December 2nd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Milton Morozalkiewicz

11 BIRTHPLACE OF FATHER (city or town) Reading
(State or country) Pa

12 MAIDEN NAME OF MOTHER Lottie Pavlinskai

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Milton Morozalkiewicz
(Address) 717 S. Port St.

15 Filed DEC 2 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-2, 1920, to 12-2, 1920, that I last saw him alive on 12-2, 1920, and that death occurred, on the date stated above, at 1.41 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) asthma

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry A Buchholz, M. D.

12/24, 1920 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Rosary	DEC 2 - 1920
20 UNDERTAKER H. G. Sadowski.	ADDRESS

Dec.—6-9-19—H. P. Co.—1000 Bks.

0.485588 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.485588

81

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S Ellwood Av. WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredrich R Marks

(a) RESIDENCE. NO. 600 S Ellwood Av. WARD 1

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bieber Marks

6 DATE OF BIRTH (month, day, and year) Jan 19 1852

7 AGE 68 Years 10 Months 17 Days | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer 011

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Freedrich Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Minnie Hubert 600 S Ellwood Ave.

15 Filed DEC 1 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to Dec. 1, 1920, that I last saw him alive on Nov. 29, 1920, and that death occurred, on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cateris-sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry P. Athey, M. D.

12 1920 (Address) 2364 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery

DATE OF BURIAL Dec 3 1920

20 UNDERTAKER Louis Heemann

ADDRESS 32 S Broadway.

CAUSE OF DEATH SHOULD BE CAREFULLY AND FULLY STATED. THE INFORMATION REQUESTED UNDER EACH HEADING IS VERY IMPORTANT. See instructions

Dec.—6-9-19—H. P. Co.—1000 Bks.

D. 48589 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48589

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 645 N Calhoun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A Bailey

(a) RESIDENCE. No. 645 N Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nehemiah Bailey.

6 DATE OF BIRTH (month, day, and year) Feb 8, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel W Hopper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nehemiah Bailey
(Address) Keene Ave Hamilton

15 Filed DEC 2 - 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1920, to Dec 1, 1920, that I last saw her alive on Nov. 30, 1920, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Cancer Liver

(duration) 4-5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter C. Bacon, M. D.

12/1/20 (Address) 100 E Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 3 1920
20 UNDERTAKER W J Fichtner & Son	ADDRESS North Ave

Amt $32.50

CAUSE OF DEATH. TION is very important. See instructions on back.

Spec. 6-9-19—H. P. Co.—1000 Blks.

20.485-90 ✓ 20.485-90

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. O'Brien

(a) RESIDENCE. No. 705 E. 21st St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~1858~~ 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Edward O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Rodder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed DEC 2-1920 Robert P. Harrison, Registrar
Daniel Perrit Clark

CAUSE OF DEATH. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1920, to December 1, 1920, that I last saw him alive on December 1, 1920, and that death occurred, on the date stated above, at 2:25 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Operative shock

Congestion (duration) yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12-1-20

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) J. A. Holden, M. D.

12/1/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Dec 3 1920
20 UNDERTAKER E. A. Woodfield Jr	ADDRESS 501 E 22 St

Baltimore, Maryland,

December 3rd, 1920.

M IT MAY CONCERN:-

s to certify that Mr. John T. Obrens said that his age is
-seven years (57-years) instead of sixty-five years (65-Years)
ven on health certificate, and furthermore wishes that same
be changed on health certificate.

Signature F. A. Holden M. D.

ber 3rd, 1920.

n in before me the ~~[redacted]~~ the subscriber a Notary
ic of the State of Maryland, residing at 902 S. Ellwood Ave.
onally appeared the above named Applicant residing at [redacted]
makes oath in due form of law that the matters and things set
h are within his personal knowledge and are true as therein set forth.

John J. O'Hara
Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48591

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1731 Clive ST.: ~~23~~ (WARD)

2-FULL NAME Sarah R. Bahnlein

(a) RESIDENCE. NO. 1731 Clive ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bahnlein

6 DATE OF BIRTH (month, day, and year): June 13 1861

7 AGE: Years 59 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City Md.

PARENTS

10 NAME OF FATHER: Alex Sittler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Benj F Bahnlein 1702 Moreland Ave

15 Filed DEC 2 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 19, to Dec 1 19 20, that I last saw h alive on Dec 1 19 20, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H E Campbell, M. D.

12/1 1920 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: 12/3/ 1920

20 UNDERTAKER: Mrs J. E. Evans Sons

ADDRESS: 1422 Ed

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

ec.—6-9-19—H. P. Co.—1000 Bks.

0.48592 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48592

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 125 Richmond St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Fraley

(a) RESIDENCE. No. 125 Richmond St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Marrd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mln.
	41 yrs	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Lizzie Fraley (Address) 125 Richmond St

15 Filed DEC 2 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Dec 1, 1920

that I last saw h.. alive on Dec 1, 1920,

and that death occurred, on the date stated above, at 10. a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dont Know any

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W K Forquer, M. D.

122 - 1920 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntsville Ala.	Dec 3rd 1920
20 UNDERTAKER	ADDRESS
Felix B. Pope	#102 E. Mulberry St.

MR V. 3603

CAUSE OF DEATH. See INSTRUCTION is very important.

Sec.—6-9-19—H. P. Co.—1000 Bks.

20.48593

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48593

8-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 W McCoun St ST. 23 WARD)

2-FULL NAME 117 W McCoun St

(a) RESIDENCE. NO. 117 W McCoun ST., 23 WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry M Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise B McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henry M Marshall (Address) 117 W McCoun

15 Filed DEC 2 - 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1920, to Dec 2, 1920, that I last saw h. alive on Dec 1, 1920, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H E Campbell M. D.

Dec 2, 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	12/6 1920
20 UNDERTAKER	ADDRESS
L. F. McCully	130 E. Fay

CAUSE OF DEATH TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48594

CERTIFICATE OF DEATH.

113

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 E Lafayette Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Teresa Connor

(Residence in Baltimore: No. 312 E. Lafayette Ave St.; 79 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	S

6-DATE OF BIRTH, Feb (Month) ....., 1841 (Day) (Year)

7-AGE, 79 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Matthew J. Connor

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary A. Grady

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. E. Connor

(Address) 1111 Monument St.

15- Filed ....., 191.... Robert P. Harrison, Registrar.

DEC 2 - 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4th 1920, to Dec. 1st 1920, that I saw h-r alive on Dec 1st 1920, and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart
Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY.....
(Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. Morgan Olin M. D.

Dec 1st 1920 (Address) 1016 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral — DATE OF BURIAL, Dec 4, 1920

20-UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Fremont Ave

Give instructions on back of certificate. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48595 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48595

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Linden

(a) RESIDENCE. No. 808 E. Pratt ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Thos. A. Linden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Elizabeth Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant
(Address)

15 Filed DEC 2 1920 19.....

Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25 19 20

17

I HEREBY CERTIFY, That I attended deceased from 10/11 19 20 to 11/25 19 20,

that I last saw h— alive on 11/20 19 20,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Interstitial Nephritis

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Simon O. Ridgely, M. D.

"25 19 20 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mercy Hospital	DEC 1 1920 19
20 UNDERTAKER	ADDRESS

Commissioner Health.

Per. Wm. G. WOODALL.

CAUSE OF DEATH TION is very important. See instructions on back

Sec. 6-9-19—H. P. Co.—1000 Bks.

0.48596 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48595

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hazelwood Ave. near Hamilton ST. 64 WARD)

REGISTERED NO.....

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Seymour

(a) RESIDENCE. No. Hazelwood Ave. near Hamilton ave ST., WARD. Raspeburg

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of V. Grant Seymour

6 DATE OF BIRTH (month, day, and year) Aug 12th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Road (State or country) Maryland

PARENTS

10 NAME OF FATHER Sylvester Ritter

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant V. Grant Seymour (Address) Raspeburg Md

15 Filed DEC 6 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1920, to Dec. 1, 1920, that I last saw h[illegible] alive on Nov. 31, 1920, and that death occurred, on the date stated above, at 6½ a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 6 yrs (?) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Jillison, M. D.

12/1/20 (Address) Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec 3 1920
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Son	Baltimore

CAUSE OF [illegible] TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48597 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48597

CERTIFICATE OF DEATH.

40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 W Lanvale ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Gibson

(a) RESIDENCE. No. 2814 W Lanvale ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. life mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Nannie L. Gibson

6 DATE OF BIRTH (month, day, and year) Feb 7, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Franklin Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Rebecca French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Nannie L. Gibson
(Address) 2814 W Lanvale

15 Filed DEC 4 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH. IMPORTANT INFORMATION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 30, 1920, that I last saw him alive on Nov 30, 1920, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant Cachexia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of Nov 30-1920

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) John A. Ostrand, M. D.

Dec 2, 1920 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 3 1920
20 UNDERTAKER	ADDRESS
W. M. Carson & Martin	

Spec.—6-9-19—H. P. Co.—1000 Bks.

Soran

D. 48598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48598

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Soran.

(a) RESIDENCE. NO. 1419 W. Layfayette av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida J. Soran.

6 DATE OF BIRTH (month, day, and year) Don't Know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	72			

086

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Dry Docks.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Soran.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cecilia Hayward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Ida J. Soran 1525 N. Bond St.

15 Filed DEC 2 1920 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920, to Dec 2, 1920 that I last saw h Im alive on Dec 2, 1920 and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lymon V. Abbott, M. D

19 (Address) Franklin Sq Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Dec. 4- 1920

20 UNDERTAKER William Cook

ADDRESS 502 E. North Ave.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

...—6-9-19—H. P. Co.—1000 Bks.

Jauri

D48599 HEALTH DEPARTMENT—CITY OF BALTIMORE D48599

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital REGISTERED NO. 37

CITY OF BALTIMORE: (No. ..... St.: 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Astilio Jauri

(a) RESIDENCE. No. 465 S. Poppleton St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L. Jauri

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	32.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor .080.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Bayview Hosp. (Address) Balt. Md.

15 Filed DEC 3 - 1920 ROBERT P. LAMOTTE Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1. 1920, to Dec. 1. 1920, that I last saw h.im alive on Dec. 1. 1920, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paresis. 0024

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Serological

(Signed) N. H. Edmunds M. D.

12/1/ 1920 (Address) Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	12/6 1920
20 UNDERTAKER John J. Cowan & Son	ADDRESS 901 Hollins St.

CAUSE OF ... TION is very important. See instructions ...

Spec.—8-24-14—M. & T.—2000 Bks.

048600

HEALTH DEPARTMENT—CITY OF BALTIMORE

048600

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 3316 Chestnut Ave (13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sula L Hood

(Residence in Baltimore: No. 3316 Chestnut Ave St.; 74 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married yes

6-DATE OF BIRTH, Jan 28 (Month) (Day), 1865 (Year)

7-AGE, 55 yrs. 11 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Ruppe

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Jane Duncan

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Hood

(Address) 3316 Chestnut Ave

15- Filed DEC 3 - 1920 191. ROBERT P. LATIMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 20 1920, to Dec 1 1920, that I saw h[illegible] alive on December 1 1920, and that death occurred, on the date stated above, at 3. A m.

The CAUSE OF DEATH* was as follows:

Pleurisy Acute

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) ..... yrs. ..... mos. 22 ds.

(Signed) C. J. Davies M. D.

12-1, 1920 (Address) 800 W. 3rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Dec 3, 1920

20-UNDERTAKER Ehrenwerth Son — ADDRESS Chestnut Ave

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Blks.

48601

HEALTH DEPARTMENT—CITY OF BALTIMORE

48601

CERTIFICATE OF DEATH.

100-091

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abe Fox

(Residence in Baltimore: No. 2215 Brookfield St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1883
(Month) (Day) (Year)

7-AGE, 37 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salesman

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Samuel Fox

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Louis Cohen Samuel X

(Address)..... 1411 E Baltimore St

15-

Filed DEC 3 - 1920 191.... ROBERT B. CARTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1920, to Dec 2 1920, that I saw h[illegible] alive on Dec 2 1920, and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows: (Exhibition of heart [illegible]
Myocarditis

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) C. B. Krauss M. D.

Dec 3, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 11 ds. In the State 30 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 2215 Brookfield Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herrington

DATE OF BURIAL, 12/5, 1920

20-UNDERTAKER Jack Levin

ADDRESS 1411 E Balto

CAUSE OF ... important. See instructions on back of ...

Peritonsillar abscess prior to cellulitis.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D.48602 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48602

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH
CITY OF BALTIMORE (No. One Mt. Royal Ter. (near Dolphin) ST.; 14 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura K. Tawneley

(Residence in Baltimore: No. 141 W. Mosher St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. 4, 1875 (Month) (Day) (Year)

7-AGE, 45 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Fred K. Tawneley

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Laura K. Webster

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Tawneley

(Address) Henderson, N.C.

15-

Filed JAN 6 1921, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

N.B.—Every item of information should be given, so that it may be properly entered in the CAUSE OF DEATH in plain terms, so that it may be properly understood. All items are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
and hemorrhage accident
(Instantaneous) (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) J. J. D. Hennessy M. D.
(Coroner.)

Jan. 6, 1921 (Address) 2802 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	1/6/20, 19....

20-UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave.

D ~~48662~~ HEALTH DEPARTMENT—CITY OF BALTIMORE D ~~46~~

CERTIFICATE OF DEATH. X 175-02

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Royston Ave (or other name)) ST. 11 WARD)

(If death ... hospital or... give its N... of street and... fill out No. ...

2-FULL NAME Agnes Thompson

(Residence in Baltimore: No. Jacksonville, Fla. St.; yrs., m...

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ... July (Month) 26 (Day), 1884 (Year)

7-AGE, 36 yrs. 7 mos. ... da.

If LESS than 1 day, ... hrs. or ... mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER, Patrick Healy

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Mary Anderson

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minia Lemire

(Address) 767 N. Lefevre Ave

15- DEC 3 - 1920 Filed ..... 191... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, ... November 24 (Month) (Day),

17- I HEREBY CERTIFY, That I took ch... remains described above, held an... (Inquest, autopsy) thereon and from the evidence obtained by said... ..... find that said deceased came to... topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
accidental fall
(Duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary) .....
(Duration) ... yrs. ... mos.

(Signed) J. J. Hennessy (Coroner)

Dec 2 1920 (Address) 2802 Edmon...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLEN... state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SU... HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTION... SIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mon...

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mount Carmel Cemetery

DATE OF BU... Dec 3...,

20-UNDERTAKER George J. Ruth

ADDRESS 1733 Hay... Av...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Alessi

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48603

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So Balto Gen Hosp ST. [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marianna Alessi

(a) RESIDENCE. NO. 822 N. Gay ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow of Charles Alessi

6 DATE OF BIRTH (month, day, and year) Unknown 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Castrogovanni Italy.

PARENTS

10 NAME OF FATHER Paul Amato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Jose. Canalone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Thomas Alessi (Address) 822 N. Gay St

15 Filed DEC 3 - 1920 ROBERT E. LEAUTE Registrar

Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1920, to Dec. 2, 1920, that I last saw her alive on Dec. 2, 1920, and that death occurred, on the date stated above, at 2459 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

Undetermined (duration) History of only 2 wks Trouble yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock. Resection of Colon (Partial) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 822 N Gay —

Did an operation precede death? yes Date of 1 Dec/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Johnson M. D.

. 19 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Dec 4 1920
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford

1048604 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048604

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 Gough St. ST.: W WARD) REGISTERED NO. C.....

2-FULL NAME Mary Kozlowski

(Residence in Baltimore: No. 2010 Gough St (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED? (Write the word.) Single

6-DATE OF BIRTH, Dec 1, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ...mos. 1 ds. If LESS than 1 day, 2 ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank Kozlowski

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Anna Derda

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Kozlowski

(Address) 2010 Gough St

15-

Filed DEC 3 - 1920, 191... Registrar.

ROBERT P. KRAUTER
DEPUTY REGISTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yr. ...mos. ...ds.

(Signed) Sheehy Ryan Dooley (Coroner) M. D.

Dec 3, 1920 (Address) 160 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Dec 3, 1920

20-UNDERTAKER William Trachowski — ADDRESS 1618 Eas

CAUSE OF DEATH. Information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048605 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048605

CERTIFICATE OF DEATH. 61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boleslaw Leszczynski

(a) RESIDENCE. NO. 310 Reynolds St ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 - 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Leszczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kath. Pomierski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record
(Address) J H H

15 Filed DEC 2 - 1920, 19 ROBERT P. LAMDIN Registrar
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, 19 20, to Dec. 2, 1920, 19—, that I last saw him alive on Dec. 2, 1920, 19—, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination Spinal Fluid

(Signed) James C. Fox, Jr. M. D.

12/2 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 4 1920

20 UNDERTAKER W M Faulkowski ADDRESS 1117 Eastern

ec.—6-9-19—H. P. Co.—1000 Bks.

D48606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D48606

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Koragianis

(a) RESIDENCE. No. 1407 N Charles ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~ or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28th 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	+	+	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Koragianis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Mary Constant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

14 Informant James Koragianis
(Address) 1407 N Charles St

15 Filed ..... 19 .....
DEC 3 - 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1920. to Dec. 7, 1920.

that I last saw h[illegible] alive on Dec. 7, 1920.

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Intentional Intoxication

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md Gen H.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical manifestations

(Signed) Fred B. Smith, M. D.

, 19 (Address) Md Gen H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: 12-3 1920

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: 178 Calhoun

TION is very important. See instructions

Baltimore, Md., December 16, 1920.

I do hereby make oath that the name of the father of the deceased on Baltimore City Certificate of Death - D-48606 is incorrect, also ame of the Mother and the Birth place of Mother.

Instead of that given on said certificate same should be as follows:

	Given on Certificate.	Correct Information.
er's name -	James Korazianis	George Karagianis.
er's Name -	Mary Constant	Sophia Glass.
er's Birthplace -	Greece	Kentucky.

Fred B Smith M. D.
Physician.

Subscribed and sworn to before me this 16th day of December, 1920.

Reed Gaither
Notary Public.

ec.—6-9-19—H. P. Co.—1000 Bks.

D 48607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 48607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S 31st ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Louise Biggs

(a) RESIDENCE. NO. 723 S. 31st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Biggs

6 DATE OF BIRTH (month, day, and year) May 23rd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James C. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Bagnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John T. Biggs
(Address) 723 S Ninth St

15 Filed DEC 3 - 1920, 19 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1920

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1917, to Dec. 1, 1920, that I last saw h.. alive on Nov. 30, 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Fisher, M. D.

Dec 1920 (Address) 1823 N. Must. 28.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec. 4th 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

TION is very important. See instructions

D48608 HEALTH DEPARTMENT—CITY OF BALTIMORE D48608

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1303 Gough St ST. 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Fries
(Residence in Baltimore: No. 1303 Gough St
St.: yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb 22, 1835
(Month) (Day) (Year)

7-AGE, 85 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dependent
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Fries

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Weber

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matilda Fries
(Address) 1203 Gough St

15-
Filed DEC 3 - 1920 191.....
ROBERT P. KRAUTER
Burial Permit Register

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 3, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thomas Fries Coroner. M. D.
Dec 3, 1920 (Address) 1800 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Dec 4, 1920

20-UNDERTAKER Tully & Julia ADDRESS 403 S. Paca St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

048609 048609 64 048609

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 176 N. East ST.; 23 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Sigard
(Residence in Baltimore: No. 176 N East St.; 7 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 11 1862 (Month) (Day) (Year)

7-AGE, 57 yrs. 7 mos. ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER, Henry Krattenberg
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER Elizabeth Fusby
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Krattenberg
(Address) 126 N. East St.

15- ROBERT B KRAUTER
Filed DEC 3 1920 Burial Permit Issued. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Dec 1 1920, that I saw h[illegible] alive on Dec 1 1920 and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 1 yrs. 9 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Chas Adams M. D.
Dec 2, 1920 (Address) 1320 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem | DATE OF BURIAL, Dec 7, 1920

20-UNDERTAKER H W & J Evans Sons | ADDRESS [illegible]

Important. See instructions on back.

Rec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D48610 15V D48610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Ellen Grant

(a) RESIDENCE. No. 1723 Gorsuch Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	6 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Joseph's Hospital Balto.

PARENTS

10 NAME OF FATHER George Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hustler Canada

12 MAIDEN NAME OF MOTHER Elizabeth E. McPhail

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: George Grant

(Address) 1723 Gorsuch Ave

DEC 3 1920

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1920, to Dec 2, 1920, that I last saw her alive on Dec 2, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm N. Freeman, M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 3 1920
20 UNDERTAKER	ADDRESS
Geo. A. Herbig	2008 W Baltimore St

...TION is very important. See instructions...

Anna Jakubowska.

Sec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48611

D48611

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1630 Thames ST.: 15 WARD)

2-FULL NAME Anna Jakubowska

(a) RESIDENCE. NO. 1630 Thames ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Jakubowski

6 DATE OF BIRTH (month, day, and year) Aug- 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	19	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Zalenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bronislawa Gorka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Jakubowski. (Address) 1630 Thames St.

15 Filed DEC 8-1920 Registered ROBERT P. KRAUTER Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1920, to Dec 3rd, 1920, that I last saw h alive on Dec 2nd, 1920, and that death occurred, on the date stated above, at 11:45a m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Gen. Phthisis 6 mos

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy Exam.

(Signed) A F Kiss, M. D.

Dec 3 1920 (Address) 24 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Bmm	Dec 4 1920
20 UNDERTAKER M. F. Ludowski.	ADDRESS 705 S. Ann

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48612.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Mc Culloh ST. 14 WARD)

REGISTERED NO. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Green

(a) RESIDENCE. No. 1741 Mc Culloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theresa Green

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22.	6	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Mc Mc Hyde

9 BIRTHPLACE (city or town). Maryland
(State or country)

PARENTS

10 NAME OF FATHER Charles Green

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hatta Hall

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harry Green
(Address) 218 Dunbarton

15 Filed DEC 3 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Dec 3, 1920, that I last saw h[illegible] alive on Dec 2, 1920, and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Caspary, M. D.

, 19 (Address) 733 Lange St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, [illegible] OF REMOVAL: Forest Pk

DATE OF BURIAL: Dec 6 1920

20 UNDERTAKER: E. B Harle

ADDRESS: 115 E Pratt St

Make ... CAUSE OF DEATH in plain terms. State ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 48613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 48613

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Italy ap. Mar Pen. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leroy Danforth

(a) RESIDENCE. NO. 3 Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Franklin Co. New York

PARENTS

10 NAME OF FATHER Albon Danforth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence. (Address) Preston Valley.

15 Filed DEC 3 1920, 19 [illegible] Registrar

Burial Permit Clerk

TION is very important. See

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 19 , 19 , that I last saw him alive on ~~Dec~~ Nov 24, 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Davies, M. D.

Dec 3, 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec. 4 1920

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Gruman St

D48614 HEALTH DEPARTMENT--CITY OF BALTIMORE D48614

CERTIFICATE OF DEATH

109

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 810 W Lombard ST.; ..... WARD) REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Stadlick

(Residence in Baltimore: No. 810 W Lombard St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
m	W	Single

6 DATE OF BIRTH July 1 (Month), — (Day), 1920 (Year)

7 AGE — yrs. 5 mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Stadelnikas

11 BIRTHPLACE OF FATHER (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Margie Kavaleuskas

13 BIRTHPLACE OF MOTHER (State or country) Lithuania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Stadelnikas

(Address) 810 W Lombard St

15 Filed DEC 3 - 1920 ROBERT J KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 2 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1920, to Dec 2 1920, that I saw him alive on December 2nd, 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Toxemia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) (Morris Abramovitz M. D.

Dec 2, 1920 (Address) 1707 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 4 1920

20 UNDERTAKER John Grebliauskas — ADDRESS 425 S Paca St

N. B.—Every [illegible] state CAUSE OF DEATH in plain terms. [illegible] is very important. See instructions on back of certificate.

ec.—6-9-19—H. P. Co.—1000 Bks.

D.48615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48615

CERTIFICATE OF DEATH.

53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loraine Elliott

(a) RESIDENCE. NO. 1026 Park Avenue Baltimore Md. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2m	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Irvin Elliott.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Pratt.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J. H. Hospital Records
(Address)

15 Filed DEC 3 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1920, to Dec 2nd, 1920, that I last saw h. Gr alive on Dec 2nd, 1920, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Leukemia.

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Usual address

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) W. W. Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec. 4th 1920

20 UNDERTAKER Edward W Pye

ADDRESS 710 Edmondson Catonsville Md

Rec.—6-9-19—H. P. Co.—1000 Bks.

No. 48616 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 48616

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1425 W Lafayette ave 16 ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Julius Dalrymple

(a) RESIDENCE. NO. 1425 W Lafayette ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena R. Dalrymple

6 DATE OF BIRTH (month, day, and year) Aug 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer State

9 BIRTHPLACE (city or town) Calvert Co Md
(State or country)

PARENTS

10 NAME OF FATHER Jesse J Dalrymple

11 BIRTHPLACE OF FATHER (city or town) Calvert Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Mattingly

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co Md
(State or country)

14 Informant Jesse J Dalrymple
(Address) 1425 W Lafayette

15 Filed DEC 3 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 30 1920, to Dec 3 1920, that I last saw him alive on Dec 2 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cebral Hemorrhage

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) E. K. Jump M. D.

19 (Address) 841 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Inner Freedom Town Md	Dec 1920
20 UNDERTAKER Calvert Co	ADDRESS Prince

TION is very important.

ec.—6-9-19—H. P. Co.—1000 Bks.

2.48617 HEALTH DEPARTMENT—CITY OF BALTIMORE 2.48617

CERTIFICATE OF DEATH. 176

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (N Bidler-Sellam Hosp (WARD)

2-FULL NAME Henry C Banks

(a) RESIDENCE. NO. 1607 E Federal ST. WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah M Banks

6 DATE OF BIRTH (month, day, and year): Sept 15 1849

7 AGE: Years 71 Months 2 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry C Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: M. E. E. Banks

(Address): 1607 E Federal St

15 Filed DEC 3 - 1920

Robert P. Harrison, Registrar

Burial Permit Clerk

Dr Geo E Houck 212 Madison St

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec 2, 1920, that I last saw h[illegible] alive on Dec 2, 1920, and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Lenticular Hypertrophy of Prostate Gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov 16 '20

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Geo. E. Houck, M. D.

, 19 (Address) 212 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemt — DATE OF BURIAL: Dec 4 1920

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

ec.—6-9-19—H. P. Co.—1000 Bks.

D.48618 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48618

CERTIFICATE OF DEATH. 53

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2801 Greenmount ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Kidwell

(a) RESIDENCE. No. 2801 Greenmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Allison C. Kidwell

6 DATE OF BIRTH (month, day, and year) Nov 2/ 1846.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74 years.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home- God
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas md.

PARENTS

10 NAME OF FATHER John Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Mary E Boysen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant Jessie Linthicum
(Address) 2801 Greenmount ave.

15 Filed DEC 3 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1920, to Dec 2nd, 1920, that I last saw h[illegible] alive on Dec 1st, 1920, and that death occurred, on the date stated above, at 7-45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Leukemia

(duration) about 3 yrs. — mos. — ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A Fair M. D.

12/3 1920 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 4 1920
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North Ave

TION is very important.

Fair.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48619

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2740 W. Fairmount ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto V Kleinstein

(a) RESIDENCE. No. 2740 W. Fairmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roselia Kleinstein

6 DATE OF BIRTH (month, day, and year) Feby 14 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Otto Kleinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible] Kleinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto J Kleinstein

(Address) 2740 W Fairmount

15 Filed 19

Robert P. Harrison,
Registrar
Burial Permit Clerk.

DEC 3 - 1920

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. ATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Dec 2, 1920, that I last saw h[illegible] alive on Dec 2, 1920, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Contracting the Lues, and Malad Regressive in Lue

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyle, M. D.

Dec 3, 1920 (Address) 662 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Dec 4 1920

20 UNDERTAKER	ADDRESS
J Herwig & Co	2008 [illegible] Ave

Spec.—8-24-14—M. & T.—2000 Bks.

0.48620 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.48620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 17 WARD) REGISTERED No. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Williams

(Residence in Baltimore: No. 118 W. 20th St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) ?

6-DATE OF BIRTH, unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, about 60 Y. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed DEC 3 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12/1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/30 1920, to 12/1 1920, that I saw h[illegible] alive on 12/1 1920, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Accidental Electrocution

Experiment

(Duration) ..... yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Syphilis Alcoholism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

12/1, 1920 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	DEC. 3 1920
20-UNDERTAKER	ADDRESS

Commissioner Health.

Per. Wm. E. WOODALL

17590

D.48621 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48621

CERTIFICATE OF DEATH. (outdoor stuer)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. S. W. Cor 4th and Hill St.: 14 WARD) 79 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	Unknown

6-DATE OF BIRTH, Unknown 1 (Month) (Day) (Year)

7-AGE, about 30 yrs. If LESS than 1 day, ...yrs.....mos.....ds. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 08

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... N. W. Police

(Address)..... City

15- Robert F. Harrison, Burial Permit Clerk, Registrar.

Filed DEC 3 1920, 191

17682

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

Dec. 2, 1920 (Address) 2802 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

DEC 1 1920

Commissioner Health.

Wm. A. WOODALL

important. See instructions on back of certificate

...c.—6-9-19—H. P. Co.—1000 Bks.

D.48622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48622

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 178 W Hamburg ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Easley

(a) RESIDENCE. NO. 178 W Hamburg ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/1/20

7 AGE	Years	Months	Days	If LESS than 1 day ½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj. Easley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nannie Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Benj. Easley 178 W Hamburg St

15 Filed DEC 3 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/20

17 I HEREBY CERTIFY, That I attended deceased from 12/1/20, 19..., to 12/1/20, 19..., that I last saw h... alive on 12/1/20, 19..., and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj Easley, M. D.

12/1/20 (Address) 908 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health.	ADDRESS DEC 2 - 1920

6-9-19—H. P. Co.—1009 Bks.

D.48623 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48623

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Aged Women's Home ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia mina M Glover

(a) RESIDENCE. No. 1400 W Lanvin Lane ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: W't

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26/1842

7 AGE: Years 78 Months 4 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hampstead Md

PARENTS

10 NAME OF FATHER: Amos Hoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hampstead Md

12 MAIDEN NAME OF MOTHER: Susa Crabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conewago Pa

14 Informant (Address): Ella J Jones Mahon

15 Filed DEC 3 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Dec 3, 1920, that I last saw h... alive on Nov 29, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Hemiplegia (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J Woodwood, M. D.

Dec 4, 1920 (Address) 739 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 6 1920

20 UNDERTAKER: George J Smith — ADDRESS: 1000 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 48624 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48624

CERTIFICATE OF DEATH. 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5222 Florence Ave ST.; 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Lavenia Hitchcock

(a) RESIDENCE. No. 5222 Florence Ave ST., 27 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse A. Hitchcock

6 DATE OF BIRTH (month, day, and year): Aug. 8-1835

7 AGE: Years 85; Months 3; Days 23; If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah Fullerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: Miss Katherine Hitchcock

(Address) 5222 Florence Ave

15 Filed ...19... Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 3 1920

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Dec 1, 1920, that I last saw h alive on Dec 1, 1920, and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Hy Goodale Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (Home)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. E. Richardson M. D.

(Dec. 3 1920 Address) 112 W. 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Dec 4 1920

UNDERTAKER: Horace Burgee & Son

ADDRESS: 363 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

James E. Svec

D.48625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48625

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 N Washington St.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Svec

(Residence in Baltimore: No. 1900 N Washington St. St.; 1 yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Single

6-DATE OF BIRTH, Nov 25, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Svec

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Annie Ruta

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Svec

(Address) 1900 N. Washington St

15-

Filed DEC 8 - 1920, 191

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from December 2 1920, to December 2 1920, that I saw him alive on December 29 1920; and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Albert Eisenberg M. D.

Dec 2 1920 (Address) 2027 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 4, 1920

20-UNDERTAKER Frank Tracy Son — ADDRESS 1906 Orleans

Lenkel

ec.—6-9-19—H. P. Co.—1000 Bks.

D.48626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48626

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3322 Myrtle Ave 26 ST. WARD)

2-FULL NAME Louisa Lenkel

(a) RESIDENCE. NO. 3322 Myrtle Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Charles Lenkel

6 DATE OF BIRTH (month, day, and year) May 1st 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Federic Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Wm. Lenkel

(Address) 3322 Myrtle Place

15 Filed DEC 4 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH. TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1920, to Nov. 1st, 1920, that I last saw h— alive on Nov. 28, 1920, and that death occurred, on the date stated above, at 7 25 P. m.

The CAUSE OF DEATH* was as follows:

Senility. Arteriosclerosis

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Blevens M. D.

Dec 2 1920 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Ger. Evangelical Cem	Dec. 4 1920

20 UNDERTAKER Jos. J. Herr ADDRESS 156 N. Luzerne ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48627 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 108

CITY OF BALTIMORE: (No. 810 2. Vincent St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 810 2. Vincent St.; all life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 29 (Day), 1891 (Year)

7-AGE, 29 yrs. 4 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 087
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Own home

9-BIRTHPLACE, (State or Country), Balto. City Md

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Charlotte Harris

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Snider

(Address) 810 Concord

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

EC4-1320

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25 1920, to Dec. 1 1920, that I saw her alive on Dec. 1 1920, and that death occurred, on the date stated above, at 6-30 a. m.

The CAUSE OF DEATH* was as follows:

Gall Stone, Appendicitis

(Duration) —yrs. —mos. 8 ds.

CONTRIBUTORY (Secondary) Peritonitis, from ruptured appendix (Duration) —yrs. —mos. 3 ds.

(Signed) Chas. L. McCorkle M. D.

Dec. 2, 1920 (Address) 906 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec. 5th, 1920

20-UNDERTAKER Sam'l. Glass & Son — ADDRESS 1400 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

0.48628 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.48628

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Druid Hill Ave ST. 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Chambers

(Residence in Baltimore: No. 1525 Druid Hill Ave St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, 3 (Month) 4 (Day), 1845 (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 5 mos. 28 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER /

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sidonia Anderson

(Address) 1525 Druid Hill Ave

15- Filed....., 191.....

Robert P. Harrison, Registrar.

DEC 4 - 192 Burial Permit Cle...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Dec 2, 1920, that I saw h.. alive on Dec 2nd 1920, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

..... (Duration)....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary) Senile Debility

..... (Duration) 2 yrs. 6 mos. ds.

(Signed) W. Brasto[illegible] M. D.

Dec 4th 1920. (Address) 354 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, Dec. 4, 1920

20-UNDERTAKER George H. Holland — ADDRESS 163 Henry St

Spec.—8-24-14—M. & T.—3000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2.48629

CERTIFICATE OF DEATH.

91-20.48629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2143 W Saratoga ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Florence McDonald

(Residence in Baltimore: No. 2143 W. Saratoga St.; ..... yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 13, 1918
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Frank McDonald

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Florence Parry

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank McDonald

(Address) 2143 W Saratoga St.

15-

Filed DEC 4 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 3 1920, that I saw h[illegible] alive on Dec 3 1920, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Semmes M. D.

Dec 3, 1920. (Address) 800 Harlem Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, 12/6/20, 191...

20-UNDERTAKER George J. Ruck

ADDRESS 1735 Harford Ave.

Spec.—8-24-14—M. & T —2000 Bks.

D.48630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48630

CERTIFICATE OF DEATH.

1590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3026 Westwood Ave St.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Irwin

(Residence in Baltimore: No. 3026 Westwood Ave St.; ....yrs.,....mos....ds.)

Lifetime

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, July 25, 1836
(Month) (Day) (Year)

7-AGE, 84 yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shipwright 86
(b) General nature of industry, business, or establishment in which employed (or employer): retired

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George W. Irwin

11-BIRTHPLACE OF FATHER (State or Country), Md —

12-MAIDEN NAME OF MOTHER Ann Baisman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Irwin

(Address) 3026 Westwood Ave

15- Robert P. Harrison,

Filed DEC 4 - 1920 191.... Burial Permit C... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7, 1920, to Dec 2 1920, that I saw him alive on Dec 2 1920, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility + Prostatitis

(Duration) ....yrs. 1 mos. 27 ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) ....yrs. 2 mos. 2 ds.

(Signed) Chas. W. Bullock M. D.

Dec. 4, 1920 (Address) 1100 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Dec 6..., 1920
20-UNDERTAKER	ADDRESS
Jerusalem Lodge	Howard and Worth Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.48631 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.48631

CERTIFICATE OF DEATH. 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 W. Lanvale ST. 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Heil

(a) RESIDENCE. No. 1719 W. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Heil

6 DATE OF BIRTH (month, day, and year) Jan 6-50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	24	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Balz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. Heil

(Address) 1719 W. Lanvale

15 Filed DEC 4 - 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from past six months, 19..., to Dec. 1, 1920, 19..., that I last saw her alive on Dec. 1, 1920, 19..., and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

abdominal aneurysm

(duration) 6 mos yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) J. C. Lound, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	Dec 4 1920
20 UNDERTAKER Philip Herring	ADDRESS 2016 Albans

CAUTION is very important. See instructions on

D.48632 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 N. Gaunty St ST.: 18 WARD) REGISTERED NO. C 104

2-FULL NAME Joseph Rhodes

(Residence in Baltimore: No. 109 N. County St. St.; yrs., 2 mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 1, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... born
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bath Co Ky

PARENTS.

10-NAME OF FATHER, Russell Rhodes

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ema Parker,

13-BIRTHPLACE OF MOTHER (State or Country), D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Rhodes

(Address) 109 N County St

15- Robert P. Harrison,

DEC 4 - 1920 191 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or,~~ inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis 7 Mal nutrition

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ....yrs. 2 mos. ....ds.

(Signed) W. R. Leonard M. D. (Coroner.)

12-3, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 5, 1920

20-UNDERTAKER Brown & Fleland — ADDRESS 114 W. Saratoga St.

CAUSE OF DEATH important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Blks.

D.48633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48633

CERTIFICATE OF DEATH.

28

24

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. US. PUBLIC HEALTH SERVICE HOSPITAL) ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM L. BLEVINS.

(a) RESIDENCE. No. US. PUBLIC HEALTH SERVICE HOSPITAL #56 ST. WARD. FORT MCHENRY MD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) UNKNOWN

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work miner.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rosenbark Registrar
(Address) U. PHSH. #56 FT. Fort McHenry Md.

15 Filed DEC 4 1920 Robert P. Harrison, Registrar

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Monember 3, 1920, to December 3., 1920, that I last saw him alive on December 3., 1920. and that death occurred, on the date stated above, at 8'40 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary (active)

Unknown (duration) --- yrs. --- mos. --- ds.

CONTRIBUTORY (Secondary) ---

--- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Thomas R. Payne, M. D.

12/3, 1920 (Address) US. PHS H. #56 Ft. McHenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roda, Wise County Va	Dec 4 1920
20 UNDERTAKER	ADDRESS 112 E Baltimore St
Sol Lewenthal Bro	

Burial Permit Clerk.

D.48634 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. B.& O.R.R.tracks Westport. St. 16 175-003 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C.Becker.Jr.

(Residence in Baltimore: No. 1129 N.Mount St. St.; 26 yrs., 1 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, October 11th. 1894., 1.
(Month) (Day) (Year)

7-AGE, 26 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Brakesman. 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... B.& O.R.R.Co.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William C.Becker Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Dollie E.Rea.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William C.Becker Sr.(father)

(Address) 1129 N.Mount St.

15- Robert P. Harrison,

Filed....., 191.....

DEC 4 - 1920 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1st. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body.
Accidentally crushed by cars drawn by engine #1660 of B.& O.R.R.Co.
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Eisenhardt M. D.
(Coroner.)

Dec. 3rd, 1920 (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 4..., 1920
20-UNDERTAKER John F Denny	ADDRESS 715 Light St

CAUSE OF DEATH must be stated in such terms as will show the disease, or other morbid condition, directly causing death, and the antecedent causes, if any, giving rise to the immediate cause, stating the underlying cause last. See instructions on back of certificate. It is important.

Rec.—6-9-19—H. P. Co.—1000 Blks.

20,48635 ✓ 20.48635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME John H. Steele

(a) RESIDENCE. NO. Lodging Houses ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector 076

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Richard W. Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Honoria Lennon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records M.T.H.

(Address)

15 Filed DEC 4 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1918, to Nov. 30, 1920, that I last saw him alive on Nov. 30, 1920, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

12-1-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Commissioner Health. ADDRESS

DEC 4 1920

TION IS VERY IMPORTANT

ec.—6-9-19—H. P. Co.—1000 Bks.

0.48636

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.48636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baybrew Hospital REGISTERED NO. 1537

CITY OF BALTIMORE: (No.) ST.: 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jodie Ray

(a) RESIDENCE. NO. 1458 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do -

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Baybrew Hosp. (Address) Balto, Md

15 Filed DEC 4 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

THIS is very important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1919, to Dec. 2, 1920, that I last saw h[illegible] alive on Dec. 2, 1920, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (2 the Insane).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lentic Conjectum.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. Goldsmith, M. D.

12/3/20 (Address) Baybrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Nov. 4 1920

20 UNDERTAKER Edw. Ringgold ADDRESS 1463 Carey St

c.—6-9-19—H. P. Co.—1000 Bks.

.48637 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48637

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 906 E Fayette St St.: 2 WARD)

2-FULL NAME Zofia Laurenska

(a) RESIDENCE. NO. 906 E Fayette St., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1878 May 15

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Laczykowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stephen Laurenski

(Address) 906 Fayette St E

15 Filed ..... 19.... Robert P. Harrison, Registrar

EC 4 - 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1920, to Dec 2, 1920, that I last saw h.e alive on Dec 2, 1920, and that death occurred, on the date stated above, at 9-15 p.m.

The CAUSE OF DEATH* was as follows:

Influenza

Uncertified

(duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Chronic Cirrh

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Lang Gross, M. D.

4/12. 19 2[illegible] (Address) 1508 McKeyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec 6 1920
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1508 Kenwood Ave

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Inflammation of Thyroid gland

Spec.—8-24-14—M. & T.—2000 Bks.

D.48638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48638

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1913 N Carlton ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Backman

(Residence in Baltimore: No. 1913 N. Carlton St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 26 (Month) (Day), 1837 (Year)

7-AGE, 83 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Johnston

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Mary Fuchs

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E J Backman

(Address) 1913 N Carlton St

15-

Filed DEC 4 1920, 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 10 1920, to December 2 1920, that I saw her alive on December 2 1920, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Albert Evander M. D.

Dec 3., 1920 (Address) 2627 Hoffman Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Dec 6., 1920
20-UNDERTAKER	**ADDRESS**
Robt Timmis	1712 Gorsuch

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

2.48639 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48639

CERTIFICATE OF DEATH.

REGISTERED No. C 130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2256 Cecil Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Alice D. Brady.

(Residence in Baltimore: No. 2256 Cecil Ave St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Feb. (Month) 1 (Day) 1854 (Year)

7-AGE, 66 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James W. Keenan

11-BIRTHPLACE OF FATHER (State or Country), Winchester Va

12-MAIDEN NAME OF MOTHER Dougherty

13-BIRTHPLACE OF MOTHER (State or Country), Winchester Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston P. Keenan

(Address) 2426 Greenmount Ave

15-

Filed DEC 4 - 1920, 1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 4 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1920, to Dec 4 1920, that I saw her alive on Dec 3 1920, and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

About (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration) yrs. mos. 4 ds.

(Signed) Mary F. Voegtlen M. D.

Dec 4, 1920 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL. Dec. 6, 1920

20-UNDERTAKER H. C. Widfeld

ADDRESS 9 E Grmount Ave

D.48640

6-9-19—H. P. Co.—1000 Blks.

D.48640 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH Robert Garrett Hosp

CITY OF BALTIMORE: (No. 27 N Carey ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally Tibbetts

(a) RESIDENCE. NO. Galt, Kent Co, Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/30/1829

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Amos Tibbetts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Amos Tibbetts Townsend Del

15 Filed C4-1920, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from November 20, 1920, to December 4, 1920, that I last saw her alive on December 3, 1920, and that death occurred, on the date stated above, at 2 45 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. W. V. Clift, M. D.

Dec 7, 1920 Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Townsend Del	Dec 6 1920
20 UNDERTAKER George J. Smith.	ADDRESS Townsend

ATION is very important. See instructions

ec.—6-9-19—H. P. Co.—1000 Bks.

48641 HEALTH DEPARTMENT—CITY OF BALTIMORE 48641

CERTIFICATE OF DEATH.

8 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1117 N. Caroline St. St.: 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie T. Healy

(a) RESIDENCE. No. 1117 N. Caroline St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Sales-woman

(b) General nature of industry, business, or establishment in which employed (or employer) Boys Clothing

(c) Name of employer Hutzler Bros.

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va.

PARENTS

10 NAME OF FATHER Thomas Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

TION is very Important

14 Informant Miss Lizzie Healy
(Address) 1117 N. Caroline St.

15 DEC 5 - 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3d 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Dec 3, 1920,
that I last saw h e alive on Dec 3, 1920,
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic endocarditis nephritis (duration) Indef yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Hayward, M. D.

, 19 (Address) 230 Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/6/20 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son,	805 N. Calvert

Lazimus Levy.

D48642 HEALTH DEPARTMENT—CITY OF BALTIMORE D48642

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 415 Pearl st ST.: 17 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lazimus Levy

(Residence in Baltimore: No. 415 Pearl st St.: yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Lazarus Levy

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME, OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1417 Bank st

15- Filed DEC 5 - 1920, 191... ROBERT P. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis disease of the head (Duration) yrs. Dont Know ds.

CONTRIBUTORY (Secondary) Dont Know Gay (Duration) yrs. Dont Know ds.

(Signed) W. H. Garner M. D. (Coroner.)

12-4, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rodgers Run	12/5, 1920
20-UNDERTAKER Jack Levin	ADDRESS 1441 E Balto st

CAUTION: This certificate should be filled out with the greatest care, as it is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

48643 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048643

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvan Gallen

(Residence in Baltimore: No. 216 N Milton ave St.; ..... yrs., ... mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. ..... Nov (Month) 6 (Day), 1900 (Year)

7-AGE. ..... yrs. ..... mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Baltimore md

PARENTS.

10-NAME OF FATHER. Benj Galler

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Rika Takolf

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Balto St

15- Filed DEC 5 - 1920, 191.... ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 4, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Dec 4 1920, that I saw h.. alive on Dec 4 1920, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

..... Post Operative shock .....

..... 0 0 0

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ..... Hypertrophic Pyloric Stenosis

..... (Duration) ..... yrs. ..... mos. 28 ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. 28 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 216 N Milton ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Rodeph Shalom Cem	Dec 7, 1920
20-UNDERTAKER Jack Levis	ADDRESS 1411 E Balto

important

Spec.—8-24-14—M. & T.—2000 Bks.

148644

HEALTH DEPARTMENT—CITY OF BALTIMORE

148644

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 217 N. Broadway ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Greenthal
(Residence in Baltimore: No. 217 N Broadway St.) 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Day) Unknown (Month) ....., 1854 (Year)

7-AGE 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Mfg Opt.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore St

15- DEC 5 - 1920 ROBERT J KRAUTER
Filed ....., 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 4 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1920, to Dec 4 1920, that I saw h[illegible] alive on Dec 4 1920, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Brights Disease
(Uraemia)

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coma, Ordema of Lungs.

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Joseph E Greenthal M. D.

Dec 5, 1920 (Address) 1526 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL, 12-7, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Baltimore

Important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048645 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 1048645

CERTIFICATE OF DEATH.

— 54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 279 N. Exeter ST. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Mirabile

(a) RESIDENCE. NO. 279 N. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., If of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosario Mirabile

6 DATE OF BIRTH (month, day, and year) Aug. 20. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	—	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer) — 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Guiseppe Donato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Mirro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosario Mirabile

(Address) 279 N. Exeter St.

15 Filed DEC 5 1920 ROBERT I KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 30, 1920, to Dec 3rd, 1920, that I last saw h.... alive on Dec 3rd, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	Dec. 6 1920
20 UNDERTAKER	ADDRESS
George J. Reuth	1735 Hanford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

648646 648646

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N. Carolina ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Walker

(Residence in Baltimore: No. 602 N. Carolina St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1858 (Year)

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Wesley Banks

11-BIRTHPLACE OF FATHER (State or Country), Md ?

12-MAIDEN NAME OF MOTHER, Sarah Jane Scott

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Chase

(Address) 1620 Mullikin St

15- Filed DEC 5 - 1920 ROBERT I KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 2 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 2/11/20 to 2 Dec. 1920, that I saw her alive on 1 Dec. 1920, and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Failure of vital organs. Several

(Duration) yrs. 2 mos. 1 ds.

(Signed) Elmayfield Bayne M. D.

3 Dec., 1920 (Address) 432 N. Carolina St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cmtry

DATE OF BURIAL, Dec 5, 1920

20-UNDERTAKER Mrs Robt A Elliott

ADDRESS 1725 Ashland Ave

important. See that

Misc.—6-9-19—H. P. Co.—1000 Bks.

648647 HEALTH DEPARTMENT—CITY OF BALTIMORE 648647

CERTIFICATE OF DEATH. 10-041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Aisquith St ST.: 5 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Stevenson

(a) RESIDENCE. No. 410 Aisquith ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Feb 16-1908

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER William Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Baltimore

12 MAIDEN NAME OF MOTHER Bessie Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Baltimore

14 Informant Mother Bessie Stevenson

(Address) 410 Aisquith St

15 Filed DEC 5 - 1920 ROBERT F KRAUSER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 - 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27 - 1920, to December 1 1920

that I last saw her alive on December 1 1920,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis + Laryngitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. M. Kennard M. D.

12-3 1920 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Dec 6 1920
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Av

FOR 24 very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048648 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048648

CERTIFICATE OF DEATH. 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St. 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Alexius Goechel

(a) RESIDENCE. No. 110 E. West St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious D65

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER John. Goechel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rosina Pfotl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rev Father Goechel

(Address) Millers Bann. Pa.

15 Filed DEC 5 - 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/3 1920

17

I HEREBY CERTIFY, That I attended deceased from 12/3 . 1920 , to 12/3 . 1920 ,

that I last saw h alive on 12/3 . 1920 ,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Cholecystitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 12h ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/3

Was there an autopsy? yes Dr. [illegible]

What test confirmed diagnosis? O.K. A. J. Riley Coroner.

(Signed) Louis O. Rigby, M. D.

12/3 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross cab	12-6 1920
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

048649

HEALTH DEPARTMENT—CITY OF BALTIMORE

048649

CERTIFICATE OF DEATH.

X 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Howard A Kelly Hosp St.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C Strickler

(Residence in Baltimore: No. The Howard A. Kelly Hospital St.; ..... yrs., ... mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, October (Month) 13 (Day), 1880 (Year)

7-AGE, 40 yrs. 1 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Salem, Virginia

PARENTS.

10-NAME OF FATHER, Joseph C Strickler

11-BIRTHPLACE OF FATHER (State or Country), Salem, Virginia

12-MAIDEN NAME OF MOTHER Ella Coleman

13-BIRTHPLACE OF MOTHER (State or Country), Roanoke Co., Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William G. Strickler

(Address) Salem Va

15- Filed DEC 5 - 1920 191.. ROBERT I KRAUTH Registrar. STATE Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1920, to Dec. 4 1920, that I saw h[im] alive on Dec. 4 1920, and that death occurred, on the date stated above, at 2[15] a.m.

The CAUSE OF DEATH* was as follows:

General Lymphosarcomatosis (primary in retro-peritoneal glands)

(Duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Nathan C Primrose M. D.

Dec. 5, 1920. (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 6 ds. In the State ... yrs. ... mos. 6 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Salem Va.

19-PLACE OF BURIAL OR REMOVAL, Salem Va

DATE OF BURIAL, Dec 7, 1920

20-UNDERTAKER Chas. G. Black

ADDRESS 742 W. Fayette

—6-9-19—H. P. Co.—1000 Bks.

048650

HEALTH DEPARTMENT—CITY OF BALTIMORE 048650

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1464 Montpelier ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory J. H. Schroder

(a) RESIDENCE. NO. 1464 Montpelier ST., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Peter L Schroder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mr. Peter L. Schroder 1464 Montpelier St

15 Filed DEC 5 - 1920 19

ROBERT J KRAUTER Registrar
Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from December 2 1920, to Dec 5 1920, that I last saw him alive on Dec 4 1920, and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Jeremy Whitbeck, M. D.

, 19 20 (Address) 1618 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec 6 1920

20 UNDERTAKER Henry Hoerle Sons — ADDRESS 1301 Edmondson

Spec.--6-9-19—H. P. Co.—1000 Bks.

2048651 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048651

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Woodbourne Ave 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo. L. Dunn

(a) RESIDENCE. No. 700 Woodbourne Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 Yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L. Dunn

6 DATE OF BIRTH (month, day, and year) Jan. 28th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tug Boat Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Mariner

(c) Name of employer Curtis Bay Towing Co.

9 BIRTHPLACE (city or town) (State or country) Accomack Co. Md.

PARENTS

10 NAME OF FATHER Geo. H. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary Co. Md.

14 Informant Margaret L Dunn (Address) 700 Woodbourne Ave

15 Filed DEC 5 - 1920, 19 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1920, to Dec 3, 1920, that I last saw him alive on Dec 3rd, 1920, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert L Kirk, M. D.

19 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Dec. 6- 1920

20 UNDERTAKER William Cook

ADDRESS 502 E. North Ave

TION is very important.

ec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048652 1048652 8P

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Barclay St. 11 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Phalen

(a) RESIDENCE. No. 1112 Barclay ST. [illegible] WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Phalen

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Wm E Phalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Brodey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Helen Phalen
(Address) 1112 Barclay St

15 Filed DEC 5 - 1920 ROBERT S. [illegible] Registrar
Burial Permit Oiert

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1920, to Dec 3, 1920, that I last saw h[illegible] alive on Dec 2, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

19 20 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 6 1920
20 UNDERTAKER	ADDRESS
Woolbook	502 E. Fayette Av.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948653 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948653

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 418 S 15 St ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E Mergardt

(a) RESIDENCE. No. 418 S 15 St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7th ds. How long in U. S., if of foreign birth yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L Mergardt

6 DATE OF BIRTH (month, day, and year) April 12/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James H Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie E Southard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Annie E Fowler (Address) 418 S 15 St

15 Filed DEC 5 - 1920 ROBERT P. KRANTZ Registrar

Burial Permit Obtained

Dr. Blanc Clinton 6 Eastern Ave.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1920, to Dec 4, 1920, that I last saw her alive on Dec. 4, 1920, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs.? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No. Date of

Was there an autopsy? No. Sputum negative Physical Signs.

What test confirmed diagnosis?

(Signed) Frank A. Glantz, M. D.

, 19 (Address) 3744 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem't	Dec 7 1920

20 UNDERTAKER ADDRESS

Wm Lock 5026 North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

d48654 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048654

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Presstman ST. 1461 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vivian Sanders

(Residence in Baltimore: No. 410 Presstman St. 1yr. 11 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, Jan 2nd, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo. Sanders

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Minnie Overton

13-BIRTHPLACE OF MOTHER (State or Country), 410 Presstman

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Minnie Sanders

(Address)..410 Presstman St.

15-

Filed DEC 5 - 1920 ROBERT F KRAUTER Register

Burial Permit

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28th 1920, to Dec 4 1920, that I saw her alive on Dec 4th 1920, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Cerebral - Spinal Meningitis
(Not Epidemic)

(Duration)....yrs. Not known mos....ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration)....yrs....mos. 3 ds.

(Signed) Harry F. Brown M. D.

Dec 5, 1920 (Address) 1501 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Dec 5, 1920

20-UNDERTAKER Wm R A Elliott — ADDRESS 1125- Pennsylvania Ave

D48655 HEALTH DEPARTMENT—CITY OF BALTIMORE D48655

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1908 Bank St) ST.: 7 WARD) 151

REGISTERED No. C.....

2-FULL NAME Dolorita Eva Winiecka

(Residence in Baltimore: No. 1908 Bank St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 15 mos. ~~7~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec 3 (Month) (Day), 1905 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 15 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Wieniecki

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Katherine Rodalony

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Wieniecki

(Address) 1908 Bank St

15- DEC 5 - 1920 ROBERT J. KRAUSE

Filed ....., 191. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Theodore Gus Paulson M. D.
(Coroner)

Dec 5 1920 (Address) 1800 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Dec. 5, 1920
20-UNDERTAKER	**ADDRESS**
John A. Weber	1803 Bank St

Important. See instructions on back of certificate.

Wunder

Dec.—6-9-19—H. P. Co.—1000 Bks.

1048656 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048656

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Wunder

(a) RESIDENCE. No. 1200 Jones St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): ~~Single~~ Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE: Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER John Wunder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Rosa Bury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Rosa Wunder 1200 Jones St

15 DEC 5 - 1920 ROBERT I. KRAUTER Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2/ 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 23, 1920, that I last saw h[illegible] alive on Dec 3, 1920, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? Clinical Symptoms & Autopsy

(Signed) Chas A Duncan, M. D.

, 19 (Address) 6 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL: Dec 7 1920

20 UNDERTAKER: W Fitchmeyer

ADDRESS: Walbrook

1048657

144540 1048657 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd M. Cox.

(a) RESIDENCE. NO. Belton South Carolina ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Cox

6 DATE OF BIRTH (month, day, and year) April 8 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER George W. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Martha Madison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Hospital Record (Address)

15 Filed DEC 6 - 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Dec 6th 1920, that I last saw h[illegible] alive on Dec 6-th 1920, and that death occurred, on the date stated above, at 720 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) duration 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? yes Date of 11/29/20

Was there an autopsy? yes

What test confirmed diagnosis? Microscopical

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Belton S. C. DATE OF BURIAL Dec 6 20

20 UNDERTAKER Geo. L. Schwab & Bro ADDRESS 2101 Eutaw

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

Fisher

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048658 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048658

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1021 Wilcox ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Fisher

(a) RESIDENCE. No. 1021 Wilcox ST., WARD.

(Usual place of abode) about

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 50 about yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of wife of Michael Fisher

6 DATE OF BIRTH (month, day, and year) Dec 11, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) County Mayo Ireland

PARENTS

10 NAME OF FATHER Martin Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) County Mayo Ireland

12 MAIDEN NAME OF MOTHER Maria Manning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) County Mayo Ireland

14 Informant James Fisher Son

(Address) 1021 Wilcox st

15 Filed DEC 6 - 1920 ROBERT R KRAUTER Registrar

Burial Permit Given

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December - 3 1920

17 I HEREBY CERTIFY, That I attended deceased from October - 7, 1920, to December - 3, 1920, that I last saw her alive on December - 3, 1920, and that death occurred, on the date stated above, at 6 p— m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Cardiac Failure -

Arteriosclerosis - Senility

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Gastro Enteritis

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H. Edwards, M. D.

12-5, 1920 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary Cemetery Evergreen	Dec 6 1920

20 UNDERTAKER ADDRESS

Elmer W Conklin 924 E Eager St.

Prec.—6-9-19—H. P. Co.—1000 Bks.

48659 HEALTH DEPARTMENT—CITY OF BALTIMORE 48659

48659 CERTIFICATE OF DEATH. 152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Lakewood Ave WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmore Celcia Drinks.

(a) RESIDENCE. No. 612 N. Lakewood Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none yet

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Drinks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Celcia Mitchel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Margaret Fields (Address) 614 N. Streeper

15 Filed DEC 6 - 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1920, to Dec. 5, 1920, that I last saw her alive on Dec 4, 1920, and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows: ovw

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Mayer, M. D.

19 (Address) 408 S Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 6 1920
20 UNDERTAKER	ADDRESS
H. Gander & Son	1710 Fort St

NOTE—IMPORTANT. See instructions on back. ATION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

48660 HEALTH DEPARTMENT—CITY OF BALTIMORE 48660

CERTIFICATE OF DEATH. 1792

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harrison Day

(a) RESIDENCE. NO. Monroe Frederick Ward Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farm Hand

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mrs. A. L. Day
(Address) Monroe & Fredk Sts. Md.

15 Filed DEC 6 — 1920 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to Dec 5, 1920, that I last saw h.m alive on Dec 5, 1920, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Empyema following pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Myocarditis + Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-4-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm McKCraig M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kemptown Cemetery Kemptown Md	Dec 7 1920
20 UNDERTAKER E & B Harle	ADDRESS City 115 E Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048661 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048661

152

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 856 St. Peter St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Adolph Backhaus.

(a) RESIDENCE. No. 856 St Peter St. St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life time mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2.	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE - ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Adolph Backhaus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wiedisch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto - Md.

14 Informant Adolph Backhaus. (Address) 856 St Peter St

15 Filed DEC 6 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5- 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1920, to Dec. 5, 1920, that I last saw him alive on Dec. 4, 1920, and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) H. G. Friedman M. D.

12 5 1920 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 6 1920
20 UNDERTAKER	ADDRESS
Geo Lemmerhirt	627 N Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

048662 HEALTH DEPARTMENT—CITY OF BALTIMORE 048662

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N Fremont Ave. St.; 4 Ward)

2-FULL NAME William H. Green

(a) RESIDENCE. NO. 105 N Fremont Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Green

6 DATE OF BIRTH (month, day, and year) July 2nd 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plant Man 066

(b) General nature of industry, business, or establishment in which employed (or employer) for C. & P. Phone Co.

(c) Name of employer Mr. Collison

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER William Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) California

14 Informant Rose Green (Address) 105 N Fremont Ave.

15 Filed DEC 6 - 1920 ROBERT P. BRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to Dec 3, 1920, that I last saw him alive on Dec 3, 1920, and that death occurred, on the date stated above, at 12-30 Noon m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Compensatory failure, pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D

Dec 4 1920 (Address) 2687 Mersens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec. 6th 1920
20 UNDERTAKER	ADDRESS
Mrs. Mrs John H. Deufel	801 W. Fayette

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1050 Bks.

048663 HEALTH DEPARTMENT—CITY OF BALTIMORE 048663

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Keeney

(a) RESIDENCE. NO. 2637 Mace St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Furman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Mary Brickley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records (Address) M.T.H.

15 DEC 6 - 1920 ROBERT I. KRAUTER Registrar

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1920, to Nov. 30, 1920, that I last saw h.. alive on Nov. 29, 1920, and that death occurred, on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Gray, M. D.

11-30-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Dec 6 1920
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

Spec.—6-9-19—H. P. Co.—1000 Bks.

0048664

HEALTH DEPARTMENT—CITY OF BALTIMORE

0048664

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 St. Paul st. ST.: 11 WARD)

2-FULL NAME Mary Edmondson Stough

(a) RESIDENCE. NO. 1015 St. Paul st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. Stough.

6 DATE OF BIRTH (month, day, and year) May 12, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~71~~	73	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Edmondson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Stough
(Address) 1015 St. Paul St.

15 Filed DEC 6 - 1920 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Dec 4, 1920, that I last saw h e alive on Dec 4, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo H. Enos, M. D.

, 19 (Address) 30 W. Biddle st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GREEN MOUNT CEMETERY CO.

DATE OF BURIAL 19

20 UNDERTAKER HENRY W. JENKINS & SONS CO.

ADDRESS 610 CHARLES & ORCHARD STS.

DEC 1920

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

048668 - HEALTH DEPARTMENT—CITY OF BALTIMORE 28 [illegible]

CERTIFICATE OF DEATH. REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2034 Orleans ST.; 6 WARD)
2-FULL NAME Anna M. Dietz
(Residence in Baltimore: No. 2034 Orleans St.; 63 yrs. ..... mos. ..... da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow
6-DATE OF BIRTH, Jan (Month) 18 (Day), 1857 (Year)
If LESS than 1 day, ...hrs. or.....min.?
7-AGE, 63 yrs. 10 mos. ..... da.
8-OCCUPATION: (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Home
9-BIRTHPLACE, (State or Country), Baltimore Md.
10-NAME OF FATHER, Martin Meyer
11-BIRTHPLACE OF FATHER (State or Country), Germany.
12-MAIDEN NAME OF MOTHER Anna Groeckel
13-BIRTHPLACE OF MOTHER (State or Country), Germany.
PARENTS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Dietz
(Address) 2034 Orleans St.

15- Filed DEC 6 - 1920, 191... ROBERT F KRAUTER Registrar. Burial Permit Issued.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 4 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-4 191.20., to 12-4 191.20., that I saw h.. alive on 12-4 191.20., and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Diabetes (Duration) ..... yrs. 6 mos. ..... da.
CONTRIBUTORY (Secondary) Accidental
(Duration) ..... yrs. ..... mos. 3 ..... da.
(Signed) ..... M. D.
12-4-20, 191.., (Address) 800 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer
DATE OF BURIAL, Dec. 7., 1920
20-UNDERTAKER Frank A. Fink
ADDRESS 415 N. Gay St.

pcs. 6-9-19—H. P. Co.—1000 Blks.

D48666 HEALTH DEPARTMENT—CITY OF BALTIMORE D48666

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH Robert Garrett Hosp REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N Carey ST. 27 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Simpson

(a) RESIDENCE. NO. 500 Strathmore Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	16	

8 OCCUPATION OF DECEASED 60

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry F. Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford

12 MAIDEN NAME OF MOTHER Frieda Grimath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr & Mrs Simpson
(Address) 500 address

15 Filed DEC 6 - 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from November 22 1920, to Dec 4, 1920, that I last saw h[illegible] alive on Dec 3 1920, and that death occurred, on the date stated above, at 8 15 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Clift M. D.

Dec 4. 1920 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 6th 1920
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

D48667 HEALTH DEPARTMENT—CITY OF BALTIMORE D48667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1613 N. Mount St. St.; 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgiana Daley

(Residence in Baltimore: No. 1612 N. Monroe St.; 68 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. May 5th, 1852.
(Month) (Day) (Year)

7-AGE. 68 yrs. 7 mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer)..... O'Neills

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm. J. Daley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Sophia O. Horn

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Gether

(Address) 4005 Belle Ave.

15-

Filed....., 191.....

ROBERT E KRAUTER
Registrar.

DEC 6 - 1920

CAUSE OF DEATH. This line must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1920, to Dec 5" 1920, that I saw h[er] alive on Dec 5" 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) 0 (Duration) yrs. mos. ds.

(Signed) O. M. Duvall M. D.

Dec 5, 1920 (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
London Park Cem	Dec 7, 1920
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St.

Form. 6-9-19—H. P. Co.—1000-Bks.

D 48668 HEALTH DEPARTMENT—CITY OF BALTIMORE D48668

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH Robt Garrett Hosp REGISTERED NO.....

CITY OF BALTIMORE: (No. 22 N Carey ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mediniger

(a) RESIDENCE. NO. 517 Payne Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm J Mediniger

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle D. Stockett

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm J Mediniger
(Address) 517 Payne Ave

15 Filed DEC 6 1920 HENRY F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1920, to Dec 7, 1920, that I last saw h.. alive on Dec 7, 1920, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... , M. D.

....., 19.. (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 6 1920
20 UNDERTAKER Joseph B. Cook.	ADDRESS 1003 N Bolton St

TION is very important. See instructions on reverse side.

D 48669 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48669

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. George St.) Franklin St Hospital (WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Morrell

(Residence in Baltimore: No. Lanvale Lane St.; yrs., 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, unknown (Month) (Day), 1855 (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): City

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm Morrell

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jennie M Morrell

(Address) 1415 W Franklin St

15-

Filed DEC 6 — 1920 191.....

ROBERT F KRAUTH
Burial Permit Clerk
(Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture L. Shoulder
Both Scapula & Humerus
Multiple Contusions
Auto Accident (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism (Duration) yrs. mos. ds.

(Signed) James W Fenton (Coroner.) M. D.

Dec 6 1920 (Address) Court House

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS):
At place Franklin St Hosp In the
of death.....yrs.....mos.....1.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Lanvale Lane

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Elder Hall	Dec 6 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 Baltimore

Cross out what is not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48670

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Flock.

(a) RESIDENCE. No. 1643 E. Fayette ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie E. Flock

6 DATE OF BIRTH (month, day, and year) Aug 17 1893.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
27.	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B C Bibb Store Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Philip Flock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER M. Bechman

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md.

14 Informant Philip Flock
(Address) 3037 Frederick Ave.

15 Filed DEC 6 - 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to December 4, 1920, that I last saw h[illegible] alive on December 4, 1920, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Sub Phrenic Abscess

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-3-20

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) B. W. Richardson, M. D.

12/14, 1920 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec. 6" 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could give no further history of any other condition. Cause unk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48671

D48671

CERTIFICATE OF DEATH.

REGISTERED NO. D48671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Glover ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Klausmeyer

(a) RESIDENCE. No. 810 N. Glover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine Klausmeyer

6 DATE OF BIRTH (month, day, and year): April 20 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Victor Klausmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Catharine Klausmeier (Address) 810 N. Glover

15 Filed ..... Registrar

TION is very important. [illegible]

DEC 6 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-4 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Dec 4, 1920, that I last saw h... alive on Dec 3 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Intreasy

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) J. Weinstein, M. D.

12-7-1920 (Address) 800 N. Bottom Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 7 1920

20 UNDERTAKER: Jos. J. Herr 156 N. ADDRESS: Luzerne

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 932

CITY OF BALTIMORE: (No. 2504 W. Mosher St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Kate Wantz

(a) RESIDENCE. No. 2504 W. Mosher St., 16 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Severious F. Wantz

6 DATE OF BIRTH (month, day, and year) Oct 30 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Houck

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Don't

13 BIRTHPLACE OF MOTHER (city or town) Know
(State or country)

14 Informant Severious F. Wantz
(Address) 2504 W. Mosher St

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 19..., to Dec 4, 19...,
that I last saw h... alive on Dec. 4, 19...,
and that death occurred, on the date stated above, at 9.50 a.m.
The CAUSE OF DEATH* was as follows:

Cardiac Failure with Uremia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	Dec 7 1920
20 UNDERTAKER	ADDRESS
Geo. Hubel & Son	2503 Edmondson Ave

TION is very important.

Burial Permit Clerk

Spec. 6-9-19—H. P. Co.—1000 Bks.

048673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48673

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 105 N Chester ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe F. Trainor

(a) RESIDENCE. No. 105 N Chester. ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 19, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Business

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Suito md

PARENTS

10 NAME OF FATHER Patrick Trainor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Tessa McMahon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Tessa Trainor
(Address) 105 N Chester.

15 Filed DEC 6 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to DEC 3, 1920.
that I last saw him alive on DEC 2 - 1920.
and that death occurred, on the date stated above, at 9 Pm m.
The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) J. C. Blake, M. D.

12/4/20 (Address) 143 Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	Dec. 7 1920

20 UNDERTAKER ADDRESS

Ed Dunning & Son. 1438 E Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

D48674 HEALTH DEPARTMENT—CITY OF BALTIMORE D48674

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 115 McMechen ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Miller

(Residence in Baltimore: No. 115 McMechen St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.) Single

6-DATE OF BIRTH, July (Month) 13 (Day), 1920 (Year)

7-AGE, ...yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John C Miller.

11-BIRTHPLACE OF FATHER (State or Country), Wisconsin

12-MAIDEN NAME OF MOTHER Anetta Seymor

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C Miller

(Address) 115 McMechen St

15-

Filed DEC 6 1920, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 3 191.., to Dec 5 192..,

that I saw h m alive on Dec 4 1920,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis.

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Cordis adhesion.

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Edward Neudoerfer M. D.

Dec 5, 1920 (Address) 24 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cemetery	Dec 6, 1920
20-UNDERTAKER	ADDRESS
E J Nunning & Son	1938 E Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-48675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D48675

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Jen Pin alley ST.; 5 WARD)

2-FULL NAME Susie Francis

(a) RESIDENCE. No. 1405 Jen Pin alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Francis

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Jones

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John Francis 1405 Jen Pin alley
(Address)

15 Filed DEC 6 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1920, to Dec 4, 1920, that I last saw h.. alive on Dec 4, 1920, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Burns, M. D.

Dec 6, 1920 (Address) 2218 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 6 1920

20 UNDERTAKER E. C. Groth — ADDRESS 1405 McElderry

Lillian Love

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48676 D 48676

CERTIFICATE OF DEATH.

REGISTERED NO. 145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.;) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Love

(a) RESIDENCE. No. 1804 E. Balto St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Love

6 DATE OF BIRTH (month, day, and year) July 17, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hannah Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1611 E. Balto St.

15 Filed . 19 Registrar

DEC 6 - 1920

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6 1920

17

I HEREBY CERTIFY, That I attended deceased from 11/12 . 19 20, to 12/6 . 19 20,

that I last saw h m alive on 12/6 . 19 20,

and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Pemphigus Agitans

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Simon D. Rodkey, M. D.

12/7, 19 20 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Woodlands	Dec 7 1920

20 UNDERTAKER Jack Lewis, ADDRESS 1611 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48677

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth H. Ford

(a) RESIDENCE. No. 1 Edgewood Ave near Harford Road WARD. Hamilton

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony D. Ford

6 DATE OF BIRTH (month, day, and year) Jan. 6 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkville Maryland

PARENTS

10 NAME OF FATHER Louis Kreafle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bremitz Germany

12 MAIDEN NAME OF MOTHER Friederich Carstens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Schneverdingen Germany

14 Informant Anthony D. Ford

(Address) Hamilton Md.

15 Filed DEC 6 - 1920 19 [illegible] Registrar

Burial Permit Clerk.

TION is very important. See reverse.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Dec. 4, 1920, that I last saw her alive on Dead Dec. 4, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intussusception of small Intestines (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 2

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Blonushas, M. D.

12-5, 1920 (Address) St. Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John's Cemetery	Dec. 8 1920
20 UNDERTAKER	ADDRESS
Frelly Lassahn & Sons	Fallston Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48678

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Griffin

(a) RESIDENCE. No. 5004 York Road St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. 18 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13/1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General natore of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER James A Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Maud E Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant James A Griffin (Address) 5004 York Road

15 Filed DEC 6 1920 KRAUER Registrar

TION is very important. Use ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/ 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 5, 1920, that I last saw h.Ew alive on Dec 6, 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? probably Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid + Clinical Symptoms

(Signed) H. H. Bishop, M. D.

. 19 (Address) York Rd + Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem't	Dec 7 1920
20 UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48679

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1545 Homestead ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E Ehmling

(a) RESIDENCE. No. 1545 Homestead ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John a Ehmling

6 DATE OF BIRTH (month, day, and year) May 5 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ab 37

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) John A Ehmling 1545 Homestead St

15 Filed DEC 6 - 1920 Robert P. Harrison Registrar

Dr Carman Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Dec 4, 1920, that I last saw h[illegible] alive on Dec 3 1920, and that death occurred, on the date stated above, at 8 45a m.

The CAUSE OF DEATH* was as follows:

Right Hemaplegia

..... (duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? 1545 Homestead

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? by symptoms

(Signed) R P Carman, M. D.

12-5, 1920 (Address) 1707 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Baltimore Cemt	
20 UNDERTAKER W. M. Cook	ADDRESS 502 E North Ave

TION is very important.

ec.—6-9-19—H. P. Co.—1000 Bks.

48680 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48680

CERTIFICATE OF DEATH. X 929

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No 819 Beaumont Ave Gest (WARD) 27

2-FULL NAME Willie E Stevens

(a) RESIDENCE. NO. 819 Beaumont Ave St. WARD. Cambridge Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Walter F Stevens

6 DATE OF BIRTH (month, day, and year): March 1854

7 AGE — Years: 66 — Months: 9 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: Thomas M Flint

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md

12 MAIDEN NAME OF MOTHER: Sarah Vickers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co Md

14 Informant (Address): Walter F Stevens Cambridge Md

15 Filed DEC 6 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Dec 4, 1920,

that I last saw her alive on Dec 4, 1920,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - right lung

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Asthma

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Cambridge Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J E O'Rockins, M. D.

, 19 (Address) 5836 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Dec 6 1920

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48681

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: — WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Palmer

(a) RESIDENCE. No. 628 Millinan St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

03

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record (Address) J. H. H.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1920, to Dec 3rd, 1920, that I last saw her alive on Dec 3rd, 1920, and that death occurred, on the date stated above, at 11.25 a.m.

The CAUSE OF DEATH* was as follows:

Cachexia Exophthalmic

Div Embolism

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Operation - Air Embolism

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of Dec 3 1920

Was there an autopsy? yes.

What test confirmed diagnosis? yes.

(Signed) Mont R. Reid, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Mt Auburn~~ Laurel Cemetery	Dec 7 1920
20 UNDERTAKER	ADDRESS
John H. Toadvin	1912 Hill St

TION is very important. See instructions on back

ESTHER E. KRAUTER

Registrar

D48682

HEALTH DEPARTMENT--CITY OF BALTIMORE

D48682

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1505 Penna ave ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary E. Elzey.

(Residence in Baltimore: No. 1505 Penna ave St.: 62 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow.

6 DATE OF BIRTH: Jan. 7, 1858. (Month) (Day) (Year)

7 AGE: 62 yrs. 11 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Green

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Peach-

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Elzey

(Addres) 1505 Penna ave

15 Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 4, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1920, to Dec 4 1920, that I saw h[illegible] alive on Dec 3. 1920, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart.

(Duration) ..... yrs. ..... mos. 14 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Herbert C. Blake M. D.

Dec. 4, 1920. (Address) 1014 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 7 1920

20 UNDERTAKER: John H. Bradun — ADDRESS 1472 Hazel St

State CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

D 48683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 48683

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1609 Ashland ave 10 WARD) ST.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oswald needles

(Residence in Baltimore: No. 1009 Ashland av St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, Sept 5, 20
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Oswald Needles

11-BIRTHPLACE OF FATHER (State or Country), West Indies

12-MAIDEN NAME OF MOTHER Katie Scarbrough

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victoria Needles

(Address) 1009 ashland ave

15- DEC 6 1920 Robert P. Harrison, Registrar.
Filed ....., 191.....
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Insley M. D.
(Coroner.)

....., 191... (Address) 4 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 6 1920

20-UNDERTAKER John H Soadum

ADDRESS 142 Lowell St

Cross out what is not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048684 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. US. PUBLIC HEALTH SERVICE HOSPITAL #56 St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Lopez.

(a) RESIDENCE. No. US. PUBLIC HEALTH SERVICE HOSPITAL #56 St. FT. MCHENRY MD Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Dyrs. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknwon

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23yrs.--		----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Mexico.

PARENTS

10 NAME OF FATHER Mr. Jose Lopez.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rosenbrook Registar

(Address) Ft. McHenry Baltimore Md.

15 Filed DEC 6 - 1920 ROBERT F. CRAVEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 4/20

17

I HEREBY CERTIFY, That I attended deceased from November 15 1920, to December 4 1920, that I last saw him alive on December 4. , 1920, and that death occurred, on the date stated above, at 10'05 am

The CAUSE OF DEATH* was as follows:

Broncho, Pneumonia.

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) ----

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) J B Rieland, M. D.

12/4/20 (Address) US. PUBLIC HEALTH S. HOSP. #56.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Finity Cemetery	dec 6 1920
20 UNDERTAKER A - Ennison & Bro	ADDRESS 1127 E Bolton St

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48685 HEALTH DEPARTMENT—CITY OF BALTIMORE D48685

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 London Ave ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Flanagan.

(a) RESIDENCE. NO. 130 London Ave ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Flanagan.

6 DATE OF BIRTH (month, day, and year) July 4. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rev Horold Arrowsmith

9 BIRTHPLACE (city or town) (State or country) Cork Ireland.

PARENTS

10 NAME OF FATHER Potrick Flanagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cork Ireland

12 MAIDEN NAME OF MOTHER Jen Kneron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John T. Flanagan. (Address) 130 London Ave.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Dec 3, 1920, that I last saw her alive on Dec 2, 1920, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. K. Skeen M. D.

Dec 6. 1920 (Address) 4107 Liberty Pike.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monte Maria Cem., Towson Md	Dec. 7 1920

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

THIS IS VERY Important. See instructions on reverse side.

Malapant

D48686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48686

CERTIFICATE OF DEATH.

174

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Joseph Malapanut

(Residence in Baltimore: No. 3908 Clairmount Ave

15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Nov. 2, 1920
(Month) (Day) (Year)

7-AGE, 38 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Malapanut

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Diana

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Malapanut

(Address) 3908 Clairmount Ave

15-

Filed ..... (Month) ....., 191.....

Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of skull, concussion of brain accidental as per Balto Steel Co.

(Duration) 14 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. O'Sullivan M. D.
(Coroner.)

Dec 5, 1920 (Address) 2802 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Sparrows Point, Md

Former or usual residence 3908 Clairmount Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
Sacred Heart Cemetery	Dec. 6th, 1920
20-UNDERTAKER	ADDRESS
Geo. J. Rutt	1735 Hanford Ave.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48687 HEALTH DEPARTMENT—CITY OF BALTIMORE D48687

CERTIFICATE OF DEATH.

122

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Landerkin.

(a) RESIDENCE. NO. Johns Hopkins Hosp. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER James P. Landerkin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Dempsey.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant (Address) J. H. Hopkins Hospital Records

15 Filed DEC 6 - 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Dec 5, 1920, that I last saw h[illegible] alive on Dec 5, 1920, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination of culture of urine.

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery.	Dec 7 1920
20 UNDERTAKER	ADDRESS
George J. Russ	1735 Harford ave

THIS IS very important. Be sure [illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

0 48688 HEALTH DEPARTMENT—CITY OF BALTIMORE 0 48688

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 941 Bennett Place ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Henrietta Schmidt

(a) RESIDENCE. NO. 941 Bennett Place ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Theodore O. Schmidt,

6 DATE OF BIRTH (month, day, and year) May 15. 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John G. Frank,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lizette Wortman,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Theodore O Schmidt
(Address) 941 Bennett Place

15 Filed DEC 6 - 1920 19 [illegible] Registrar
Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 28th, 1920, to Dec 5th, 1920, that I last saw her alive on Dec 4th, 1920, and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj O McCleary, M. D.

12/7/1920 (Address) 1000 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park Cem. DATE OF BURIAL Dec 8.1920

20 UNDERTAKER Geo W Little ADDRESS 531 N. Fremont

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

048689 HEALTH DEPARTMENT—CITY OF BALTIMORE 048689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 S. Catherine St.: 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ulrich

(a) RESIDENCE. No. 24 S. Catherine St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Tuttle

6 DATE OF BIRTH (month, day, and year) April 7th 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Conrad Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hesse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Dauginger
(Address) 24 S. Catherine St

15 Filed DEC 6 - 1920 [illegible] Registrar

Burial or Removal Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Dec 4th, 1920, that I last saw him alive on Dec 3, 1920, and that death occurred, on the date stated above, at 4 10 p.m.

The CAUSE OF DEATH* was as follows:

Traumatic Tetanus

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) A. Hilbert Hemming, M. D.

12/6 1920 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec 7th 1920

20 UNDERTAKER F. B. Keyser — ADDRESS 2236 Eutaw Ave

(Over)

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48690

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Bank ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Overdick

(a) RESIDENCE. No. 1816 Bank ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Overdick

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Smrise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Edward Overdick

(Address) 1816 Bank St

15 Filed DEC. 6 - 1920 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26th, 1920, to Dec 4th, 1920, that I last saw her alive on Dec 4th, 1920, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Levinson, M. D.

12 6 1920 (Address) 308 B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 1st Evangelical Lan.

DATE OF BURIAL Dec. 7 1920

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Lead St.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48691

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Sterling ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Pembleton

(a) RESIDENCE. No. 630 Sterling ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Pembleton

6 DATE OF BIRTH (month, day, and year) Nov. 20-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Store Work

(c) Name of employer A. Frank Balto. Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Chas. Pembleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Seth,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Pembleton (Address) 630 Sterling St.

15 Filed [illegible] 1920

Registrar

DEC 6 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Dec 2, 1920, that I last saw him alive on Dec 2, 1920, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

OVER

Chronic Bronchial asthma

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) acute myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yr.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) G. G. Hornstein M. D.

12/5, 1920 (Address) 733 Argyle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetary	Dec. 7 1920
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	467 Pratt

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tubercular
No further history.

MW D. 596-D.

Spec.—8-24-14—M. & T.—2000 Bks.

648692

HEALTH DEPARTMENT—CITY OF BALTIMORE

648692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Gilmor ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Jane Agburn

(Residence in Baltimore: No. 513 N Gilmor St.; ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 18th, 1889
(Month) (Day) (Year)

7-AGE, 31 yrs. 9 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Taylor Agburn

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Fannie Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy Adams

(Address) Union Level Va

15-

DEC 6 1920 [illegible] Registrar.

Filed ....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Dec 6 1920, that I saw her alive on Dec 5 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

1. Cardiac Cardiitis Chronic
This Patient has been under my Care at Intervals for 2 yrs
(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Endocarditis & Abscess of Liver (Duration) 2 mos. 1 mos. ..... ds.

(Signed) J. M. Hayes M. D. Jas C. Carter M. D.

12-6-, 1920. (Address) Derby 513 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Union Level Mecklenburg Co Va

19-PLACE OF BURIAL OR REMOVAL, Union Level Mecklenburg Co Va

DATE OF BURIAL, Dec 6, 1920

20-UNDERTAKER Jno W Chase Sons

ADDRESS 450 Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048693 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048693

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Preston W. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Baumann

(a) RESIDENCE. NO. 518 W Preston St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Baumann

6 DATE OF BIRTH (month, day, and year) July 25 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Effi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marya Effi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Baumann

(Address) 518 W Preston St

15 Filed DEC 6 - 1920 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1920, to Dec 4, 1920, that I last saw him alive on Dec 3, 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Cystitis Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Claudius M. D.

19 20 (Address) 150 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/6 1920
20 UNDERTAKER Geo A Farley	ADDRESS Fulton & Fayette

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48694 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48694

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ____ St.: Municipal Tuberculosis Hospital 5 Ward)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Deegan

(a) RESIDENCE. No. 964 W. Baltimore St., ____ Ward. ____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
50 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Deegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Cullum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant City Hospital Records

(Address) ~~Robert F. Harrison,~~

15 DEC 8 - 1920 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 18 1920 to Dec. 5 1920, that I last saw him alive on Dec. 5, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Bacilli in sputum

(Signed) L. Rigney, M. D.

, 19 (Address) Municipal TB. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	12-7 1920
20 UNDERTAKER H Cummings Son	ADDRESS 5.7 Schroder

TION IS very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

D.48695 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. Green & Lombard ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Gibson

(Residence in Baltimore: No. 116 Monastery Ave. Irvington St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, M. C. 5, 1889 (Month) (Day) (Year)

7-AGE, 46 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Michael Hynes

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Mary Hynes

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hynes

(Address) 117 W. Franklin St

15-

Filed DEC 6 1920 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 4th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 30 1920, to Dec. 4th 1920, that I saw her alive on December 4th 1920, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Post Operative Shock

..... (Duration).....yrs.....mos.....ds.

(Signed) Jack W. Hendley M. D.

....., 191... (Address) University Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 12-7-, 1920

20-UNDERTAKER H. B. Hemmings & Co — ADDRESS 517 N. Schroeder St

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48696 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48696

CERTIFICATE OF DEATH.

1524

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 311 N Greene ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Zurliene

(Residence in Baltimore: No. 311 N. Greene st St.; 67 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. f.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, ... Jan. (Month) ..... 29 (Day), 1832 (Year)

7-AGE, 88 yrs. 10 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gerhardt Dehnker

11-BIRTHPLACE OF FATHER (State or Country), Germ

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germ.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Zurliene

(Address) 311 N. Green st

15-

Filed DEC 5 - 1920 Robert F. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 4 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1916, to Dec. 21 1920, that I saw her alive on Nov 27 1920, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Senile deterioration

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthenia Collapse

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) W. H. Wakefield M. D.

Dec. 4 1920 (Address) 424 N. Greene St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Dec. 7, 1920
20-UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48697 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48697

D.48697

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Eutaw ave ST.; Fardenville WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline A. Rauber

(a) RESIDENCE. NO. 22 Eutaw ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Louis Rauber

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Louis Rauber

(Address) 22 Eutaw ave

15 Filed ..... Robert P. Harrison Registrar

DEC 6 - 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1920 to Dec 5th 1920, that I last saw her alive on Dec 5th 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs Symptoms

(Signed) Edw. A. Bowers, M. D.

, 19 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 9 1920
20 UNDERTAKER Pinkler & Pinkler	ADDRESS 1739 Eager

SECTION is very important. See instructions on back of certificate.

1442 20.48698 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ 20.48698

CERTIFICATE OF DEATH. H 1

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Rogers Jr.

(a) RESIDENCE. No. 3816 Roland Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9th 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Correspondent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant (Address) Mrs. Sofia Pinard 3816 Roland Ave

15 Filed DEC 6- 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1920, to Dec 5th, 1920, that I last saw h[illegible] alive on Dec 5th, 1920, and that death occurred, on the date stated above, at 1770 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma - retroperitoneal

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) V. R. Mason, M. D.

XII, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Dec. 7 1920

20 UNDERTAKER Horace Burgee Son ADDRESS 363 Fallsrd

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48699 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48699

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. City Hospital, Bay ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hennenberger.

(a) RESIDENCE. No. 1302 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hennenberger Reisterstown.

6 DATE OF BIRTH (month, day, and year) Sept. 17th 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness maker.

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hennenberger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Wenitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Records. (Address) City Hospital, Bay View

15 Filed DEC 6-1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1920.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Dec. 5, 1920, that I last saw h alive on Dec. 5, 1920, and that death occurred, on the date stated above, at 12 M.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio - sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) P. Boehman M. D.

Dec 5, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 7th 1920
20 UNDERTAKER E. Schloman & Son	ADDRESS, 539 Hanover St

TION is very important. See instructions on ba

Spec. 6-9-19—H. P. Co.—1000 Blks.

Bowen

D.48700 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48700

CERTIFICATE OF DEATH. 6 152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 72 N. Carey ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kendall Bowen

(a) RESIDENCE. No. 72 N Carey St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/6/20.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Nora Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Nora Bowen

(Address) 224 S. Carey St

15 Filed DEC 6- 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6/20

17 I HEREBY CERTIFY, That I attended deceased from 12/6/20, to 12/6/20, that I last saw h alive on 12/6/20, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia - drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E K Meyer M. D.

12/6, 19 20 (Address) 2638 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	12/6 19 20
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E Balto

TION IS very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

D.48701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48701

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada Sifford

(Residence in Baltimore: No. St. Elizabeth's Home St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	black	

6-DATE OF BIRTH, January (Month) 14 (Day) 1918 (Year)

7-AGE, 2 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Ada Sifford North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, Clerk.....
Filed ....., 191.....
Registrar.

DEC 6 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 3 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 1917, to December 2 1920, that I saw her alive on December 2 1920, and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

1 (a) Chronic Bronchitis

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Rachitis (severe grade)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J. Ayd M. D.

Dec 3, 1920 (Address) 2005 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS - 1320

JOHNS HOPKINS HOSPITAL

Commissioner of Health.

DEC 1920

Possibly tuberculosis.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48702

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Oak St.; W. WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Higgs

(Residence in Baltimore: No. 4 hrs. St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S.

6-DATE OF BIRTH, Dec 4, 1920 (Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 4 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Enoch Higgs

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ellie May Barnett.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellie M. Higgs

(Address) 2210 Oak St. Temporary Letters

15-

Filed....., 191.... Registrar.

Robert P. Harrison, Commissioner Health,

Permit Clerk.

Call for disposal.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 4 1920, that I saw h— alive on Dec 4 1920, and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

Cerebral Hydrocephalus

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Roscoe Stroman M. D.

Dec 4, 1920 (Address) 1438 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Johns Hopkins Hospital

DATE OF BURIAL, Dec 6, 1920

20-UNDERTAKER Per. Wm. E. WOODALL

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D.48703 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 E. Chase ST.; 8 WARD) 28

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman F. Bunsch

(Residence in Baltimore: No. 1916 E. Chase St.: 23 yrs., 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Sing.

6-DATE OF BIRTH, July (Month) 23 (Day), 1897 (Year)

7-AGE, 23 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cl Store
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Bunsch

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Rosa

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Bunsch

(Address) 1916 E. Chase St

15- Filed DEC 6 1920, 191.... Robert F. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1917, to Dec 4 1920, that I saw him alive on Dec 4 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Edema

(Duration) yrs. mos. ds.

(Signed) Edward Leo Tracy M. D.

12/5-20, 192.. (Address) 1113 N. Washington Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Dec 7, 1920
20-UNDERTAKER	ADDRESS
Frank Enoch & Son	1916 E. Chase St

D. 48704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48704

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Minarik

(Residence in Baltimore: No. 1214 ~~Chatsworth~~ Beach St Curtis Bay

25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 1 1895
(Month) (Day) (Year)

7-AGE, 62 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Jezek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Katerina Stransky

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Minarik

(Address) 1214 Beach St

15- DEC 6 - 1920 Robert P. Harrison,
Filed ....., 191.... Registrar.
Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (accidental clearing lighted stove with gasoline)

16 days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) A. J. Pudy M. D.
(Coroner.)

Dec 6, 1920 (Address) 1637 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 16 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cedar Hill — DATE OF BURIAL, Dec 9, 1920

20-UNDERTAKER Frank Enack Son — ADDRESS 1906 Woodall

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48705 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48705

CERTIFICATE OF DEATH. X 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Huntington Ave ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) former residence

2-FULL NAME Mary A Cook

(a) RESIDENCE. NO. 2826 Huntington Ave WARD. unknown

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow James J Cook

6 DATE OF BIRTH (month, day, and year) Aug 17 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McCaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James J Cook

(Address) 2826 Huntington Ave

15 Filed DEC 6 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3. 1920, to Dec 4th 1920, that I last saw h[illegible] alive on Dec 4th 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Infection of Common Duct

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) over

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical data alone

(Signed) Wm V. Watson, M. D.

Dec 5, 1920 (Address) 2178 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemt	Dec 7 1920

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

2217 St Paul Dr Watson Ph 1542

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48706

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Ensor ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arch. A. Thompson

(a) RESIDENCE. NO. 1801 Ensor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Thompson

6 DATE OF BIRTH (month, day, and year) March 21 1[illegible]0

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Store Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Amos Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Katherine Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Margaret Feston 1801 Ensor St.

15 Filed DEC 6 1920, 19[illegible] Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1920, to Dec 4, 1920, that I last saw h[illegible] alive on Dec 4 1920 and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis, Chronic Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Feston, M. D.

19 (Address) 1100 Ostend

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 12-7 1920

20 UNDERTAKER William Cook

ADDRESS 502 E North

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48707 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48707

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1703. St Paul. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L May.

(a) RESIDENCE. NO. 1703. St Paul. ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or ~~WIFE of~~) Geo May

6 DATE OF BIRTH (month, day, and year) unknown 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43.-			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry F Lippo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Booze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo May

(Address) 1703. St. Paul

15 Filed DEC 6 1920 19 Robert P. Harrison Registrar

By Nathan Kemit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 6th, 1920, that I last saw h.. alive on Dec 6th, 1920, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

(Chronic) Endocarditis (Syphilis)

(duration) 6 yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection,

(Signed) [illegible] M. D.

, 19 (Address) 1106 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alexandria Va via Alex J	1920
20 UNDERTAKER	ADDRESS
Newbrook.	

c/o James Whan Permit Clerk. Via. RR.

TION is very important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1048708 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048708

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1216 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary W. Smith

(Residence in Baltimore: No. 1216 McCulloh St.; 66 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 4, 1854
(Month) (Day) (Year)

7-AGE 66 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo Stearns

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Elmira Lawalee

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen E. Atkinson

(Address) 1216 McCulloh St.

15- Filed DEC 7 - 1920, 191... ROBERT I. KRAUTH Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Dec 4 1920, that I saw h[er] alive on Dec 4 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Gastro-enteritis, Infections of Bladder

(Duration) 2 yrs. ... mos. ... ds.

(Signed) W. Lane, M. D.

Dec 4, 1920 (Address) 923 Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Friends Cem

DATE OF BURIAL, Dec 7, 1920.

20-UNDERTAKER Chas E. Branch

ADDRESS 801 Madison Ave

Important. See instructions on back of this blank.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1648709 1648709

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Mc Elderry ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Thomas.

(a) RESIDENCE. NO. 1121 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Thomas

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Co Md

PARENTS

10 NAME OF FATHER Arbren Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Louisa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant (Address) Jack Lewis 1411 Eliot St

15 Filed DEC 7 - 1920 19 ROBERT I. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 6 - 1920

17

I HEREBY CERTIFY, That I attended deceased from 12 - 5 -, 1920, to 12 - 6 -, 1920, that I last saw h[er] alive on 12 - 5 -, 1920, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Coronary Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

, 19 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cem — DATE OF BURIAL 12/8 1920

20 UNDERTAKER Jack Lewis — ADDRESS 1411 Eliot

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

0948710 HEALTH DEPARTMENT—CITY OF BALTIMORE 0948710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital 6 109 REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.; .....6..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Minnie Reisch

(Residence in Baltimore: No. 222 N. Luzerne St.; .....yrs. 5 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) Aug 6 (Day), 1920 (Year)

7-AGE, ...yrs. 5 mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Hyman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mrs Gantman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Baltimore St

15- Filed DEC 7 1920 191..... ROBERT F KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 6 1920, that I saw h[illegible] alive on Dec 6 1920, and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Intussusception

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Charles D. Lacy M. D.

12-6-20, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Workmens Circle Mt Carmel	12-7-, 1920
20-UNDERTAKER Jack Levis	ADDRESS 1411 E Balt

important. See instructions on back of Certificate.

D48711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48711

CERTIFICATE OF DEATH.

REGISTERED NO. C 122

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isadore Novick

(Residence in Baltimore: No. 2318 E. Fairmount Ave St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) , 1 (Day) (Year)

7-AGE, 47 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Novick

(Address) 2318 E. Fairmount Ave

15- Filed DEC 7 - 1920 101 ROBERT E KRAUTER Registrar.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Hypostatic~~ Pyonephrosis

Shock. Cancer Lower Lip 1 yr.

operation. Cable (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Dec 6, 1920 (Address) 639 Cary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death 20 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Workmen's Circle

DATE OF BURIAL, 12 — 1920

20-UNDERTAKER Jack Levin

ADDRESS 1411 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

14656 1048712

HEALTH DEPARTMENT—CITY OF BALTIMORE 1048712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 104

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Hackman

(a) RESIDENCE. NO. 949 Ridgewood Ave ST., Baltimore Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2yr ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Hackman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Irene Wortman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J. H. Hospital Records
(Address)

15 Filed DEC 7 - 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 23 - 20, 1920, to Dec 5, 1920, that I last saw him alive on Dec 5, 1920, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Above address Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W. H. Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Dec 7 20
20 UNDERTAKER	ADDRESS
Jamako Lyfor	1600 Ave Norfolk Va

TION is very important. See instructions on back of certificate.

1048713 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048713

Jones

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 767 Sarah ann ST.: 4 WARD) 79 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Jones

(Residence in Baltimore: No. 767 Sarah ann St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Dont know

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 75 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hilbidon Butler

(Address) 1433 argyle ave

15-

Filed DEC 7 - 1920 191. ROBERT F KRAUTER Burial Permit Clerk
Registrar.

CAUSE OF DEATH to be plainly written. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease & the Heart

(Duration)..... yrs. Dont know mos. ds.

CONTRIBUTORY (Secondary) Dont Know If Any

(Duration)..... yrs. mos. ds.

(Signed) N. R. Gomach M. D.
(Coroner.)

12-6, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, national Cemetery — DATE OF BURIAL, Dec 7, 1920

20-UNDERTAKER John H Todrum — ADDRESS 1421 Hill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

0048714 HEALTH DEPARTMENT—CITY OF BALTIMORE 0048714

CERTIFICATE OF DEATH. 58-041

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 624 N. Eden ST.; 5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Taylor

(a) RESIDENCE. NO. 624 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28, 1920

7 AGE Years 0 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bf. Mdge Co. Md

12 MAIDEN NAME OF MOTHER Ruth Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Du Bois Pa

14 Informant Ruth Taylor (Address) 624 N. Eden St.

15 Filed DEC 7 - 1920 ROBERT S KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5/1920

17 I HEREBY CERTIFY, That I attended deceased from 11-19- , 1920, to 12-5- , 1920, that I last saw him alive on 12-4- , 1920, and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough (duration) 6 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. B. Hawkins M. D.

12/6/1920 (Address) 1216 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery | DATE OF BURIAL DEC 7 1920

20 UNDERTAKER C. C. Frost | ADDRESS 1405 McElderry

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48715

CERTIFICATE OF DEATH.

37 D48715

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Columbia ave ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony B. Griffin

(a) RESIDENCE. No. 1118 Columbia ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy Man

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Anthony Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie Griffin
(Address) 118 Columbia ave

15 Filed DEC 7 - 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec 5, 1920, that I last saw him alive on Dec 4, 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Paresis of the Brain.

(duration) yrs. 3 mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony Boyd, M. D.

1921 (Address) 602 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 9 1920
20 UNDERTAKER	ADDRESS
John J Fields	208 W Lombard

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Suicide

D48716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48716

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1518 Hanover St. ST.: 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Simpa

(Residence in Baltimore: No. 1518 Hanover St. St.; 66 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, June 28th. 1844, 1 (Month) (Day) (Year)

7-AGE, 76 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sewing machine
(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie Rumenap (daughter)

(Address) 1518 Hanover St.

15- Filed DEC 7- 1920, 191.... ROBERT B KRAUTER Burial Permit Clerk

Cause of death to be printed in plain letters. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Fernhardt M. D. (Coroner.)

Dec. 6..., 1920. (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Louden Park	Dec. 8..., 1920
20-UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948717 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital 120 REGISTERED NO.

CITY OF BALTIMORE: (No. Wilkens Ave. Balto ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Alice Tate

(a) RESIDENCE. No. 3000 Stafford ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21 yrs.	4	13 days	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shirt Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. W. Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Rachael Tittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Chas P. Tate
(Address) 3000 Stafford St.

15 Filed DEC 7 - 1920 ROBERT B [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 6, 1920, that I last saw h[illegible] alive on Dec 6, 1920, and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Appendicitis Resulting in Left Chronic Empiegma

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) W. H. Wearn M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 9 1920
20 UNDERTAKER Harry A. Nitzke	ADDRESS 1531 W. Lombard St

TION is very important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

1048718 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048718

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles B Hall

(Residence in Baltimore: No. 1411 McCulloh St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 3 (Day) 1880 (Year)

7-AGE, 30 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver (Wagon)
(b) General nature of industry, business, or establishment in which employed (or employer): 023

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Hall

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maria Brooy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hooper

(Address) 643 S Stoltzman St

15-

Filed Dec 7 1920, 191 ROBERT E KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1920, to Dec 3 1920, that I saw him alive on Dec 2 1920, and that death occurred, on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(Duration) 2 yrs. mos. ds.

(Signed) M. F. Smith M. D.

Dec 7, 1920 (Address) 115 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec 7, 1920

20-UNDERTAKER Samuel Hemsley ADDRESS 578 W Baltimore St

Spec.—6-9-19—H. F. Co.—1000 Bks.

1048719 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048719

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Patapsco ST. 23 WARD)

2-FULL NAME William N. Reuter

(a) RESIDENCE. No. 1611 Patapsco ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? 8 yrs. 4 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Curtis Reuter

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret [redacted]

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Curtis Reuter (Address) 1611 Patapsco

15 Filed DEC 7 - 1920 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1920, to Dec 4, 1920, that I last saw h[redacted] alive on Dec 4, 1920 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chorea Minor

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

1b Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Lamporel, M. D.

(Address) 1604 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	12/7 1920
20 UNDERTAKER	ADDRESS
I. Fiss McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48720 HEALTH DEPARTMENT—CITY OF BALTIMORE D48720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 W Ostend St.; 23 WARD) REGISTERED No. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Wesley Woodland.

(Residence in Baltimore: No. 113 W Ostend St.; 65 yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, 1 (Month) 4 (Day), 1855 (Year)

7-AGE, 65 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 030

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wesley Woodland.

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Sarah Linton

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Muskett

(Address) 113 W Ostend

15- Filed DEC 7 - 1920 ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11 27 1920, to 12, 5 1920, that I saw him alive on 12, 5 1920, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis 10 hours

(Duration) yrs. mos. ds.

(Signed) R. J. Burlington M. D.

12-6, 191... (Address) 1028 Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London PK Cem

DATE OF BURIAL, 12/8, 1920

20-UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

Important. See instructions on back of Certificate.

D48721 HEALTH DEPARTMENT--CITY OF BALTIMORE D48721

CERTIFICATE OF DEATH

119

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. Calvert Court Apts ST. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William S Sampson

(Residence in Baltimore: No. Calvert Court apts St.: 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH Nov 15th, 1879 (Month) (Day) (Year)

7 AGE 41 yrs. — mos. 21 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Treasurer
(b) General nature of industry, business, or establishment in which employed (or employer) Backus Motor Co

9 BIRTHPLACE (State or country) Brazil

PARENTS

10 NAME OF FATHER Squire Sampson

11 BIRTHPLACE OF FATHER (State or country) Penna

12 MAIDEN NAME OF MOTHER Laura Porter

13 BIRTHPLACE OF MOTHER (State or country) Alabama

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Charles P. Sampson

(Address) Calvert Court

15 Filed DEC 7 - 1920, 191 ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 6th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29th, 1920, to Dec. 6th 1920, that I saw h in alive on Dec 6th, 1920 and that death occurred, on the date stated above, at 10 3/4 a m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) — yrs. — mos. 7 ds

Contributory (SECONDARY) Unknown

(Duration) — yrs. — mos. — ds.

(Signed) Jefferies Rieck M. D.

Dec 6th, 1920 (Address) 2644 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL L. Park — DATE OF BURIAL Dec 9, 1920

20 UNDERTAKER John Carmichael — ADDRESS 1201 W. Fayette St

NO. DEATHS from CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14781 D48722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48722

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles O Disney jr.

(a) RESIDENCE. No. #422 n Carrollton Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore Md.

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Mr Chas O Disney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland, Howard County

12 MAIDEN NAME OF MOTHER Florence Phelps

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14
Informant) th Hospital Records
(Address)

15 Filed DEC 7 - 1920 ROBERT I KRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 — 4 — 1920

17
I HEREBY CERTIFY, That I attended deceased from Dec 3d, 1920, to Dec 4, 1920,
that I last saw him alive on Dec 4, 1920,
and that death occurred, on the date stated above, at 3 PM.
The CAUSE OF DEATH* was as follows:
(a) Shock following operation for
removal of sarcoma of kidney at
(b) Sarcoma Kidney rt - (Metastases)
(duration) yrs. 2 mos. ds.
CONTRIBUTORY None
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-4-20

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of tumor tissue

(Signed) T. ff. Thomson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 7 1920

20 UNDERTAKER	ADDRESS
John A Mitchell	1201 W Fayette

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48723

CERTIFICATE OF DEATH.

17 17

1-PLACE OF DEATH
CITY OF BALTIMORE; (No. 2112 St Paul ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Scott

(Residence in Baltimore: No. 2112 St. Paul St.; 63 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, May (Month) 26 (Day), 1838 (Year)

7-AGE, 82 yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jos. Atwell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maryann Tucker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Scott

(Address) 2112 St Paul St.

15-

Filed DEC 7 - 1920, 191.....

ROBERT B KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 5th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1917, to Dec 5" 1920, that I saw h.. alive on Dec 5" 1920, and that death occurred, on the date stated above, at 3.00 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

3

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pyelitis

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) O. McDuvall M. D.

Dec 7 20, 191... (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	Dec 8, 191.
20-UNDERTAKER	ADDRESS
John A. Mitchell	1117 Fayette St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048724 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048724

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2222 Orleans ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence V. Shelton

(a) RESIDENCE. No. 2222 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. 17 ds. How long in U. S., if of foreign birth? 67 yrs. — mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt John P. Shelton

6 DATE OF BIRTH (month, day, and year) Nov 18/53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Seal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs James Bartlett (Address) 2222 Orleans St

15 DEC 7 - 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1920, to Dec 5, 1920, that I last saw her alive on Dec 4, 1920, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dissection &c

(Signed) Adolph C. Wiesberg, M. D.

Dec 7, 1920 (Address) 2201 x 03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery Cecil Co Md.

DATE OF BURIAL: Dec 8 1920

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

D48725 HEALTH DEPARTMENT—CITY OF BALTIMORE D48725

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 235 n Kenwood ST. 6 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. ~~Henry~~ Klassner Klaussner

(Residence in Baltimore: No. 235 n Kenwood St.; Wks. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH. ..... May ..... 16th ....., 1854
(Month) (Day) (Year)

7-AGE. 66 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Musician
(b) General nature of industry, business, or establishment in which employed (or employer)..... D....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER. Henry Klaussner

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Bernard Lehmincke

(Address)..... 235 N. Kenwood

15-

Filed DEC 7 - 1920, 191... ROBERT B KRAUTER Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 5, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Dec 8, 1920
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Oliver

CAUSE OF DEATH must be plainly written. All questions important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48726 HEALTH DEPARTMENT—CITY OF BALTIMORE D48726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Federal St ST.: 8 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William N. Zepp

(a) RESIDENCE. NO. 2319 Federal St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2. 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	—	4	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Tilden Zepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Laura Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Tilden Zepp Father

(Address) 2319 E Fed St

15 DEC 7 - 1920 ROBERT A. LEAUTER (Registrar) Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 — 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 25 —, 1920, to December 6 1920, that I last saw him alive on December 6 - 1920, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease + Complications Disease (duration) 11 yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. G. Weinrand M. D.

12-6 1920 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Carroll Co Md	Dec 9 1920
20 UNDERTAKER John Herwig & Co	ADDRESS 200 E Balto

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D48727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48727

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Ulrich al. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Harris

(a) RESIDENCE. No. 1422 Ulrich al ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Albert Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frona Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Albert Harris
(Address) 615 Penn Ave N.W. D.C.

15 Filed DEC 7 - 1920 16 ROBERT B. KRAUTER Registrar
BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to Dec 5, 1920, that I last saw h~~im~~ alive on Dec 5, 1920, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Exam of urine

(Signed) Robt J Green M. D.

12-6, 1920 (Address) 126½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Dec 7 1920
20 UNDERTAKER John W Henderson	ADDRESS 1602 E Monument

TION is very important. See instructions on back of certificates.

D48728 HEALTH DEPARTMENT—CITY OF BALTIMORE D48728

CERTIFICATE OF DEATH.

182

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 506 Moore alley St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Black-Lucy

(Residence in Baltimore: No. 506 Moore alley St.: yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH, April (Month) 1 (Day), 1900 (Year)

7-AGE, 20 yrs. 7 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Middletown, Va

PARENTS.

10-NAME OF FATHER, William Black

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (N.W.) Police Dept

(Address) Balto. Md

15- Filed DEC 7 1920 191.... ROBERT J. BRAUER Registrar. Burial Permit Given

CAUSE OF DEATH: In plain terms, and as exactly as important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of chest (Homicide) 15 min.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Dec. 6, 1920 (Address) 1502 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

15-PLACE OF BURIAL OR REMOVAL, Middletown Va

DATE OF BURIAL, Dec 7, 1920

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D48729

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Hampsett Road ST. Hamilton WARD 2)

2-FULL NAME Frederick J Huber

(a) RESIDENCE. No. 41 Hampsett Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. California How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, ~~Wife of~~) Pauline F Huber

6 DATE OF BIRTH (month, day, and year) Feby 25th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machenist 031

(b) General nature of industry, business, or establishment in which employed (or employer) Flynn & Emrich Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Pauline Huber

(Address) 41 Hampsett Road Same

15 Filed DEC 7 - 1920 ROBERT B. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1920, to Dec 6, 1920, that I last saw h~~e~~r alive on Dec 6, 1920, and that death occurred, on the date stated above, at 1030 a. m.

The CAUSE OF DEATH* was as follows:

apoplexy. (Cerebral (Hemorrhage) Left Hemiplegia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Semmes, M. D.

Dec 19 20 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 9th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Bros	1126 E Monument

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048730 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048730

CERTIFICATE OF DEATH.

1479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Brunt ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Serenna Carroll

(a) RESIDENCE. No. 1922 Brunt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1-1869

7 AGE 51 Years 6 Months 5 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 041

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER James Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt Peters
(Address) 1922 Brunt St

15 Filed DEC 7 - 1920 ROBERT E. REMOTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Dec 5, 1920,

that I last saw her alive on Dec 5, 1920,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William Frey, M. D.

12/5, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cmty	Dec 8 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Hutton P. Harris ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 3 Hoffman

(Residence in Baltimore: No. 326 W. Fayette St.; 33 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, 3d Jan., 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country) Philadelphia

PARENTS.

10-NAME OF FATHER, Robert Purnell

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Williams

(Address) 324 Hoffman St.

15-

Filed DEC 7 - 1920, 191.... ROBERT E. SLAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July, 1920, to Dec. 4th, 1920, that I saw h[illegible] alive on Dec. 4th 1920, and that death occurred, on the date stated above, at 9:40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec. 7, 1920 (Address) 722 Lamdin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 8, 1920

20-UNDERTAKER George H. Holland — ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificate.

2661 Reeb

Spec.—6-9-19—H. P. Co.—1000 Bks.

648732 HEALTH DEPARTMENT—CITY OF BALTIMORE 648732

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Dover St. WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Leet

(a) RESIDENCE. NO. 1836 Dover. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Henry Leet

6 DATE OF BIRTH (month, day, and year) Feb 1 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework P 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August C. Kebl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine E. Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Henry Leet (Address) 1836 Dover St

15 DEC 7 - 1920 ROBERT I KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Dec 1, 1920, that I last saw her alive on Dec 1, 1920, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Pulmonary Edema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) E. Heller Hennig M. D.

12/6 1920 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 9 1920

20 UNDERTAKER Geo. L. Schwab & Bro ADDRESS 210 Fulton Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Johnson

143040 D48733 HEALTH DEPARTMENT—CITY OF BALTIMORE D48733

CERTIFICATE OF DEATH. 6 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Johnson

(a) RESIDENCE. NO. 722 N. Dallas St. Baltimore Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20. 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	0	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy Stamford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) J H H

15 Filed DEC 7 - 1920 ROBERT B. BRAUER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1920, to Dec 5th 1920, that I last saw him alive on Dec 5th 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? above address Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) W. W. Dawson, M. D.

, 19 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec. 7 1920
20 UNDERTAKER	ADDRESS
Mrs J. G. Lucks.	1302 Jefferson Ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48734 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48734

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Johnson

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Unknown~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 887

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ~~Unknown~~ John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Mary E. Stevens 12/6/20

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed DEC 7 1920 19 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 12 1912, to December 6, 1920, that I last saw him alive on December 5, 1920, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) R. Heaman, M. D.

(Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	DEC 8 1920
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48735 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48735

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1901 Hollins St. St.: 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Powers

(a) RESIDENCE. No. 1901 Hollins St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10" 1916

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
4	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Powers

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Nichols

13 BIRTHPLACE OF MOTHER (city or town) Washington Co. (State or country) Maryland

14 Informant Mrs. Bertha Powers (Address) 1901 Hollins St.

15 Filed DEC 7 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5" 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Dec 5, 1920, that I last saw h[illegible] alive on Dec 5, 1920, and that death occurred, on the date stated above, at 10,45 m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Examination

(Signed) [illegible] M. D.

127. 1926 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec. 8" 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gilts St.

TION is very important. See instructions on back of

D.48736 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 815 Aisquith St.; 10 WARD) 168
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Raynard,
(Residence in Baltimore: No. 815 Aisquith St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED? (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, white 60 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Street Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Don't Know.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rev. V. Ridgely
(Address) 1031 E. Monument St

15- DEC 7 1920. Robert P. Harrison, 191..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Asphyxia Climatic
Arteriosclerosis (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. Kerr Fowler M. D.
(Coroner)
191... (Address) 5 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Dec. 7, 1920
20-UNDERTAKER William Cook	ADDRESS 3025 E. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 48737 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48737

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 102 Maryland ave ST.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Zinn

(Residence in Baltimore: No. 102 Maryland ave 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Widower

6-DATE OF BIRTH, Jan. 15, 1842
(Month) (Day) (Year)

7-AGE, 78 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Saloon Keeper

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Zinn

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick W. Winslow

(Address) 102 Maryland Ave

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

DEC 7 - 1920

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Atm Smith (Coroner) M. D.

....., 191... (Address) 49 E. Lex St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Dec. 8, 1920
20-UNDERTAKER William Cook	ADDRESS 502 S. Monroe Ave

CAUSE OF DEATH in plain terms, as may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48738 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH service hospital #56 REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. ST. WARD 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Coleman.

(a) RESIDENCE. No. US PUBLIC HEALTH SERVICE HOSPITAL #56 ST. WARD. BALTO. MD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner.

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Ruenbuck Registrar

(Address) Ft. McHenry Balto. Md

Filed DEC 7- 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4/20

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1920, to Dec. 4. 1920, that I last saw him alive on Dec. 4. 1920, and that death occurred, on the date stated above, at 7'30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic pulmonary active.

-- (duration) - yrs. ------- mos. ds.

CONTRIBUTORY (Secondary) ----- --- (duration) -- yrs. ------ mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of --

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory findings

(Signed) J D Reichard, M. D.

12/4 1920 (Address) Ft. McHenry Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elko, P.O. Henrico Co, Va	Dec 7. 1920
20 UNDERTAKER	ADDRESS 1127 E Balto St
S. Ellison & Bro	

TION is very important. See instructions on back of certificates.

D48739 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48739

156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 844 N. Howard ST.: 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Davis

(Residence in Baltimore: No. 844 N. Howard St.; yrs., 6 mos..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	unknown

6-DATE OF BIRTH, ... unknown ....., about 1880
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
About 40 yrs..... mos..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Truck Dr. 063
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Police Disk,

(Address) Baltimore Md.

15-

Filed DEC 7 — 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by illuminating gas

1/2 hr.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 7, 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cem	12-8....., 19....
20-UNDERTAKER	ADDRESS 17 S
Wolf Brooks & Son	Calhoun St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48740 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48740

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. ..... ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Carroll

(a) RESIDENCE. NO. Hillsdale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. J. Carroll

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Charles J. Carroll,
(Address) Hillsdale Md.

15 Filed DEC 7 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6. 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Dec 6, 1920, that I last saw her alive on Dec 6, 1920, and that death occurred, on the date stated above, at 6.25 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma - Jaundice

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Dec. 3. 1920.

Was there an autopsy? Partial

What test confirmed diagnosis? Operative findings

(Signed) F.C. Making - M. D.

12-7-, 1920 (Address) St Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 8" 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1802 W. Baltimore St.

TION is very important. See instructions on back of certificates.

D.48741 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48741

CERTIFICATE OF DEATH. 103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 313 W. Madison ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Palmer

(Residence in Baltimore: No. 813 W. Madison St.; 45 yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, June (Month) 19 (Day) 1875 (Year)

7-AGE, 45 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: musician
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Herman Palmer Sr.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Palmer.

(Address) 313 W. Madison St.

15-

DEC 7 1920

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart
5 minutes (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion
15 minutes (Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D.
(Coroner.)

Dec 7, 1920 (Address) 1602 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Dec 8, 1920
20-UNDERTAKER	ADDRESS
Wm Cook	North & Penna

Spec.—6-9-19—H. P. Co.—1060 Bks.

1048742 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048742

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 McHenry ST. 19 WARD)

2-FULL NAME Chas. E. Collins

(a) RESIDENCE. No. 1843 McHenry ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Collins

6 DATE OF BIRTH (month, day, and year) July 5, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wireman 029

(b) General nature of industry, business, or establishment in which employed (or employer) A. D. Tel Co

(c) Name of employer C. Bennett

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Snow Hill Md

12 MAIDEN NAME OF MOTHER Ambia Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Snow Hill Md

14 Informant Julia Collins

(Address) 1843 McHenry St

15 Filed DEC 8 1920 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920, to Dec 5, 1920, that I last saw her alive on Dec 5, 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 4 Hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Fred Koldenow M. D.

19 (Address) Dec 7 1920 3450 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Dec 8th 19

20 UNDERTAKER A. Jones

ADDRESS 1017 D. St Strider

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48743

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 E Lombard ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zlata Golda Koliozr

(Residence in Baltimore: No. 1705 E. Lombard St.; 14 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 77 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Rozmbrg

(Address) 1705 E. Lombard St.

15- DEC 8 - 1920 Filed....., 191... ROBERT E LEAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2d 1920, to Dec 7 1920, that I saw her alive on Dec 7th 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) ..... yrs. 5 mos. 6 ds.

(Signed) Benj. Kovadov M. D.

Dec. 8, 1920. (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	Dec. 8th, 1920.
20-UNDERTAKER	ADDRESS
Jacob Lewis	1411 E. Baltimore St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048744

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048744

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Edwards ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane A. Young.

(a) RESIDENCE. No. 114 N. Edwards Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maiden Lady

6 DATE OF BIRTH (month, day, and year) Sept 1, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Keeper 086

(b) General nature of industry, business, or establishment in which employed (or employer) Star Knop Jewelry Co

(c) Name of employer Barnie & Johnson

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles C Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Jane Killon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Carrie L Redmond

(Address) 114 N Edwood Ave

15 DEC 8- 1920 ROBERT B FRAZIER Registrar

Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1920, to Dec 6, 1920, that I last saw h e alive on Dec 5, 1920, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation &c

(Signed) Adolph C Eisenberg, M. D.

Dec 6 1920 (Address) 1201 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery Dec 9	1920

20 UNDERTAKER Elmer W Conklin ADDRESS 924 E Eager st.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48745 HEALTH DEPARTMENT—CITY OF BALTIMORE D48745

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 N. Catherine ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Arniger

(a) RESIDENCE. No. 47 N. Catherine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William H. Arniger.

6 DATE OF BIRTH (month, day, and year) March 15 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander C. Berry.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Elizabeth Sheldon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Elizabeth Berry.

(Address) 47 N. Catherine St.

15 DEC 8-1920 ROBERT B KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1920, to Dec 6, 1920, that I last saw h[illegible] alive on Dec 6th, 1920, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis - Arterio sclerosis.

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

Dec 7th 1920 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 10 1920

20 UNDERTAKER Geo. A. Starkey ADDRESS 1201 W. Balto

CAUSE OF DEATH must be properly established. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

1948746 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948746

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lee near Charles Sts. ST.: 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A. Apple.

(Residence in Baltimore: No. 1109 Leadenhall St. St.: 49 yrs., 4 mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, July 31st. 1871., 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
49 yrs. 4 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver of Asp cart
(b) General nature of industry, business, or establishment in which employed (or employer): 023

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry A. Apple.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Barbara Geisler.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Apple. (mother)

(Address) 1109 Leadenhall St.

15- Filed DEC 8 - 1920 ROBERT E KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) H. Kennard X M. D.
(Coroner.)

Dec 8 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	12/8/20
20-UNDERTAKER J. J. Raby & Son	ADDRESS 1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L048747

L048747

CERTIFICATE OF DEATH.

REGISTERED No. C 15 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 N Fulton Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie M Houck

(Residence in Baltimore: No. 1554 N Fulton Av St.: 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Jan 2nd (Month) (Day) 1886. (Year)

7-AGE,	If LESS than 1 day,
34 yrs 11 mos 5 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER. Patrick Owen Kelly

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Ellen Harding

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Leroy Houck

(Address) 1554 N Fulton Av

15- Filed DEC 8 - 1920 1921 ROBERT B. BRAUTIGAM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7, (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1918, to Dec. 7, 1920., that I saw her alive on Dec 6, 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Dis.

(Duration) 1 yrs. mos. ds.

(Signed) Theodore H. Morrison M. D.

, 191... (Address) 1013 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lakewood — DATE OF BURIAL, Dec. 10..., 192.

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 W North Av

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048748

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048748

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent's Asylum St., 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Theresa McSpurgen

(a) RESIDENCE. No. St. Vincent Asylum St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Marion Noppinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant St. Vincent Asylum
(Address) 1401 Druid Hill Ave

15 Filed DEC 8 - 1920 19 Registrar ROBERT J. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 16, 1920, to Dec 3, 1920, that I last saw h[er] alive on Dec 2, 1920, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) (5 lb. at Birth)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Chandler M. D.

Dec 5, 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 5 1920

20 UNDERTAKER M. Fahey's Sons ADDRESS 1021 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48749

CERTIFICATE OF DEATH.

151 D48749

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 119 N. Port ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna M. Bogy

(a) RESIDENCE. No. 119 N. Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1920

7 AGE — Years — Months — Days: 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles E. Bogy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna M. Wetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Chas. E. Bogy
(Address) 119 N. Port st

15 Filed DEC 8 - 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Dec 7, 1920, that I last saw h.. alive on Dec 6, 1920, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

[illegible] 6 1/2 months

[illegible]

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 830 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec. 8 1920

20 UNDERTAKER: Girkler & Girkler — ADDRESS: 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

1048750 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048750

CERTIFICATE OF DEATH. 108

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Clara Amanda Miller

(Residence in Baltimore: No. 3455 Chestnut ave St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec 25, 1872
(Month) (Day) (Year)

7-AGE, 47 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) ..... At home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Washington Appleby

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Zepp

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. Miller

(Address) 3455 Chestnut Ave.

15- DEC 8 - 1920 Filed ....., 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30 1920, to Dec. 5 1920, that I saw her alive on Dec. 5 1920, and that death occurred, on the date stated above, at 3.00 P.m.

The CAUSE OF DEATH* was as follows:

Appendiceal abscess
Operation- appendectomy
and Drainage
(Duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) General Peritonitis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) W. E. Owens M. D.

Dec. 5, 1920 (Address) Univ. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State 48 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 3455 Chestnut ave.

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden

DATE OF BURIAL, Dec 8, 1920

20-UNDERTAKER Chenowith Son

ADDRESS Chestnut ave

important. See instructions on back of certificate.

Tittle

D48751 HEALTH DEPARTMENT—CITY OF BALTIMORE D48751

64

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Milvale Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sinai Hospital

2-FULL NAME John H. Tittle

(Residence in Baltimore: No. Milvale Ave Milvale

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colord	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer): Road Repair

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER, Thomas Tittle

11-BIRTHPLACE OF FATHER (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER Louise Thater

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria Tittle

(Address) 1677 N. Calhoun St

15-

Filed DEC 8-1920, 191.....

ROBERT P. PRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [signature] M. D.
(Coroner.)

Dec 5, 1920 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Dec 8, 1920

20-UNDERTAKER H S Marshall

ADDRESS 3539 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48752

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 D48752

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2819 Green mount Ave ST. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Ella Johnson

(Residence in Baltimore: No. 2819 Green mount Ave ST.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 4 (Day), 1869 (Year)

7 AGE: 51 yrs. 5 mos. 3 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Charles Longfield

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: MacBeth

13 BIRTHPLACE OF MOTHER (State or country): France

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas B Johnson

(Address) 2819 Greenmount Ave

15 Filed DEC 8 - 1920, 191.... ROBERT B KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 7 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920. to, Dec 7 1920 that I saw h[illegible] alive on Dec 6, 1920. and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation -
Toxemia -

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY) Pneumonia Broncho

(Duration) yrs. mos. 5 ds.

(Signed) Harry C. Algire M.D.

Dec 7, 1920 (Address) 3640 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral | DATE OF BURIAL: Dec 9, 1920

20 UNDERTAKER: A L Marshall | ADDRESS: 3539 Falls Rd

1048753 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048753.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier #5 Locust Point. St.: 24th WARD) 81 REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Lowicki.

(Residence in Baltimore: No. 1443 Richardson St. 24 ----------. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. May 29th, 1870., 1 (Month) (Day) (Year)

7-AGE, 50 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Poland.

PARENTS.

10-NAME OF FATHER. Edward Lowicki.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Teofilia Oleksik.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Lowicki.(wife).

(Address) 1443 Richardson St.

15- Filed DEC 8-1920, 191... ROBERT E KRAUTER Clerk Burial Permit Register

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th, 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autops (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry & autopsy (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sclerosis of the coronary arteries with acute dilatation of the heart.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Rosenwald M. D. (Coroner.)

Dec 7th, 1920, 191... (Address) 1917 E. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Dec. 9, 1920
20-UNDERTAKER	ADDRESS
John M. Weber	1843 Bank St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48754

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W Lakout St ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M Stuart

(a) RESIDENCE. No. 1316 W Lakout St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Morgan Stuart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Chas Co Md

12 MAIDEN NAME OF MOTHER Fannie Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St Mary's Co Md

14 Informant Father
(Address) 1316 Wlakout St

15 Filed DEC 8 1920 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1920, to Dec 6, 1920, that I last saw him alive on Dec 6, 1920, and that death occurred, on the date stated above, at 11A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J Morris Rose, M. D.

12-7, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 8th 1920
20 UNDERTAKER	ADDRESS
Garrett Leavitt	1364 McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEANS. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

448755 HEALTH DEPARTMENT—CITY OF BALTIMORE 1498758

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Ball

(a) RESIDENCE. No. 11 S. Duncan st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Ball

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Solomon Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 8 - 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Dec. 6, 1920, that I last saw her alive on Dec. 6, 1920, and that death occurred, on the date stated above, at 11.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. Hilgrey, M. D.

12-6-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millers Wnf st Marys Co Md	Dec 10 1920
20 UNDERTAKER Mrs Robt Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 48756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48756

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 811 W. Franklin St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Connor

(Residence in Baltimore: No. 811 W. Franklin St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH. ..... Dont Know (Month) ..... (Day) ....., 1864 (Year)

7-AGE.	If LESS than 1 day,
56 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(h) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Chas. Cash

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Walker

(Address) 811 W. Franklin St

15- Filed DEC 8 - 1920 ROBERT B. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) ..... 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart from History a few months (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) Dont Know yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

12-6, 1920 (Address) 11 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 7, 1920
20-UNDERTAKER	ADDRESS
John H Owens	538 Dolphin St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-15—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48757 ✓ 50 D48757

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. New City Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Schafer

(a) RESIDENCE. NO. 112 Albemarle St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schafer

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~52~~ 52.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records,

(Address) New City Hospital.

Filed DEC 8-1920 ROBERT B. IRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 20, 1920, to December 6, 1920, that I last saw h... in alive on December 6, 1920, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - sclerosis (old cerebral thrombosis)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Urinary tests.

(Signed) B Herman, M. D.

12/6/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislovas	Dec 7, 1920
20 UNDERTAKER	ADDRESS
John L Grebliunas	425 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D48758 HEALTH DEPARTMENT—CITY OF BALTIMORE D48758

CERTIFICATE OF DEATH.

56

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 408 N Front. St. 5 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Booth.

(Residence in Baltimore: No. 408 N Front St (3rd Floor) St.: yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, ... Not known (Month) ....., 1 (Day) ..... (Year)

7-AGE, 46 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 031

9-BIRTHPLACE, (State or Country) Dublin Ireland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country) Not Known.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. D. Blinder

(Address) 1423 N. Broadway

15-

Filed DEC 8 - 1920 191.....

ROBERT F. KRAUTER
Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 6 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased enme to ... death on the dny stated above.

The CAUSE OF DEATH* was as follows:

Accidental

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. William Plitt M. D.
(Coroner)

12/7/20, 191... (Address) 1423 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of denth.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore, Md. DATE OF BURIAL, 12/10, 1920

20-UNDERTAKER J. J. Fleischaught ADDRESS 2620 St. Paul St

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48759

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 W Fayette St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Beck

(a) RESIDENCE. NO. 817 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dec

6 DATE OF BIRTH (month, day, and year) July 4 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Wagner
(Address) 21 N. Fremont Ave

15 Filed DEC 8 - 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 - 19 20

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1915, to Dec 6, 1920.

that I last saw her alive on Dec 5, 19 20,

and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Arteio-sclerosis 0 0 0

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

Dec 8. 1920 (Address) 2687 Virginia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 9 - 1920

20 UNDERTAKER H. Brauning Son ADDRESS 617 N.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cal 3043

Spec.—6-9-19—H. P. Co.—1000 Bks.

2048760 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048760

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Local Apartments Eutaw St.; 11 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Conner Heis

(a) RESIDENCE. No. Local Apartments ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Edith S. Heis (nee Sanders)

6 DATE OF BIRTH (month, day, and year) June 20th 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Naval Stores

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stevenson Heis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Isabella Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant L. May Conner (Address) Local Apartments

15 Filed DEC 8 - 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 , 1920 , to Dec-7 , 1920, that I last saw him alive on Dec-6 , 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Occlusion of Coronary Artery

(duration) 3 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Malta

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination

(Signed) John J. Ling M. D.

Dec-7 , 1920 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-9 1920
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son Co	Orchard & McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48761 HEALTH DEPARTMENT—CITY OF BALTIMORE D48761

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Brice ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gross

(a) RESIDENCE. No. 417 N. Brice ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Gross

6 DATE OF BIRTH (month, day, and year) Sept 15 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Temes Set Andras Hungara

PARENTS

10 NAME OF FATHER Paul Noll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungara

12 MAIDEN NAME OF MOTHER Margaret Plattinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungara

14 Informant George Gross (Address) 417 N. Brice St.

15 Filed DEC 8 - 1920 19 ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Dec 6, 1920, that I last saw her alive on Dec 5, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Secondary to Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Cachexia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Unknown

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry Gross, M. D.

8/12 1920 (Address) 1508 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 8 1920
20 UNDERTAKER	ADDRESS
Geo. A. Gerbig	2001 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048762

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048762

CERTIFICATE OF DEATH.

19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Chapel ST.: 6 WARD)

2-FULL NAME Theresa Gossman

(a) RESIDENCE. No. 414 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gossman

6 DATE OF BIRTH (month, day, and year) Mar 27-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Casper Hohman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Given

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Given

14 Informant Casper Gossman
(Address) 414 N. Chapel St

15 Filed DEC 8-1920 ROBERT J. FEATHER Registrar, Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 1920, to Dec. 6 1920, that I last saw her alive on Dec. 3 1920, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

12/7, 1920 (Address) 701 Ilkenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec 9th 1920
20 UNDERTAKER	ADDRESS
Geo M. Frick & Son	811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48763 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 48763

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 920 N Coeymans ST.; ward 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hoffman

(a) RESIDENCE. NO. 920 N Collington Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha A Hoffman

6 DATE OF BIRTH (month, day, and year): June 24-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick maker O/W

(b) General nature of industry business, or establishment in which employed (or employer): Smith & Swartz

(c) Name of employer: Maryland

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Barbara Patrick

(Address) 920 N Collington Ave

15 Filed DEC 8 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 - 1920, to Dec - 7 1920, that I last saw h— alive on Dec 6 1920, and that death occurred, on the date stated above, at 4 Am m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 21 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William J. Roemek, M. D.

12/7/20 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 10 1920

20 UNDERTAKER: Wm C. Miller

ADDRESS: 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Curran

(a) RESIDENCE. No. 1417 Mulberry St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas Curran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records.
(Address) New City Hospital.

15 DEC 8-1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1920

17

I HEREBY CERTIFY, That I attended deceased from December 2, 1920, to December 7, 1920, that I last saw h... alive on December 7, 1920, and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Non-protein nitrogen of blood.

(Signed) H. Kelly Carman M. D.

12/7/. 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick's Cemetery	Dec. 10 1920
20 UNDERTAKER Henry Hoen & Son	ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48765

5

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Exeter ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Krager

(a) RESIDENCE. NO. 417 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Aged	64	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Bernard Krager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Stamman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Louis Krager
(Address) 417 N. Exeter

15 Filed ..... 19 ..... Registrar

DEC 8 - 1920

ROBERT I. KRAUTER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to Dec 7, 1920, that I last saw him alive on Dec 6 1920, and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Humerus Left

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E W Ricard, M. D.

, 19 (Address) 1908 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 10 1920
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48766

CERTIFICATE OF DEATH.

91 D48766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1255 Riverside Ave ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa. Hunt

(a) RESIDENCE. No. 1255 Riverside Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a [redacted] widowed, [redacted]

(or) WIFE of William A Hunt

6 DATE OF BIRTH (month, day, and year) Dec 14th 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Frankenmuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Angela Miller (Address) 1142 Battery Ave

15 Filed DEC - 1920 19 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 30 1920, to Dec 6 1920, that I last saw her alive on Dec 5 1920, and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jorge L. Duane, M. D.

19 (Address) 724 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & Co	12/9 1920
20 UNDERTAKER E & B Hark	ADDRESS 115 E Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48767

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Cathedral ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Martin M. D.

(a) RESIDENCE. No. 1000 Cathedral ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Elizabeth Bigelow Martin

6 DATE OF BIRTH (month, day, and year) 1863-10-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	1	16	

8 OCCUPATION OF DECEASED 054

(a) Trade, profession or particular kind of work Physician

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brookville
(State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER James D. Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Lucretia Warfield

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Elizabeth Bigelow Martin
(Address) 1000 Cathedral St.

15 Filed 19 Robert P. Harrison, Registrar
EC 8-1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Dec 7, 1920, that I last saw h~~im~~ alive on Dec 7, 1920, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical findings

(Signed) Harry Adler, M. D.

, 19 (Address) 18 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12-9 1920
20 UNDERTAKER Harvey W. Jenkins & Sons Co	ADDRESS McCulloh Orchard.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48768 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48768

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Morrison Court Clinton Bay ST. 175 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Barlow

(a) RESIDENCE. No. 1406 Morrison Court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 7-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Clinton Bay (State or country) Md.

PARENTS

10 NAME OF FATHER Clinton La Barlow

11 BIRTHPLACE OF FATHER (city or town) Elliott City (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy Horstman

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D. C.

14 Informant Clinton Lee Barlow
(Address) 1406 Morrison Court

15 Filed DEC 8 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1920, to Dec 7, 1920, that I last saw h[illegible] alive on Dec. 7, 1920, and that death occurred, on the date stated above, at 12 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

about 7 mos.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

12/8 1920 (Address) 211 Church St. Clinton Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 8 - 1920
20 UNDERTAKER	ADDRESS
Commissioner Health.	

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48769 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48769

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 E. Federal ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Lassahn

(a) RESIDENCE. No. 1902 E. Federal ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. C. Lassahn

6 DATE OF BIRTH (month, day, and year) Jan. 2nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Possville
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Mosby

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Mamie Lassahn
(Address) 1902 E. Federal St.

15 Filed DEC 8- 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1919, to Dec 6, 1920, that I last saw h alive on Dec 6, 1920, and that death occurred, on the date stated above, at 1030 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus, Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1902 E. Federal St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Howard Kelly, M. D.

12/9 1920 (Address) 5027 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec. 9 1920
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Baltimore Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48770

79

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 S. Potomac ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdelena Kowalska

(a) RESIDENCE. No. 908 S Potomac ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mns. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Frank Kowalski

(Address) 908 Potomac st

15 Filed Dec 8 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1920, to Dec 6, 1920, that I last saw h[illegible] alive on Dec 6, 1920, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy & Dilatation of heart (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M J McAvoy, M. D.

Dec 8 1920 (Address) 629 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec. 9 1920
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1848 S. Kenwood ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48771 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48771

CERTIFICATE OF DEATH.

79 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 E Preston ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J griffin Hall

(a) RESIDENCE. No. 2023 E Preston ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina G Hall

6 DATE OF BIRTH (month, day, and year) Jan 12 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Penna RR

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nelson Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Renshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Lina Hall
(Address) 2023 Preston

15 Filed DEC 8 - 1920, 19 Robert P. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from 29 Nov, 19 20, to 7 Dec., 19 20, that I last saw him alive on 7 Dec, 19 20, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Several yrs. — mos. ds.

CONTRIBUTORY (Secondary) Enlarged Prostate with retention of urine (duration) 1 yr. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Sandrock, M. D.

Dec 8. 1920 (Address) 1242 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 10 1920
20 UNDERTAKER	ADDRESS
John Herwig & Co	2008 Orleans

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48772

CERTIFICATE OF DEATH.

9V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Harford ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Preston

(a) RESIDENCE. No. 1333 Harford ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B. Preston

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Atlas 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Litchfield

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant William Preston (Address) 1333 Harford ave.

15 Filed DEC 8 - 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1920, to Dec. 7, 1920, that I last saw h[illegible] alive on Dec. 7, 1920, and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Gobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Robt J. Grimm, M. D.

12-8, 1920 (Address) 120 1/2 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 10 1920
20 UNDERTAKER John Hervey & Co	ADDRESS 2008 Eutaw

Burial Permit Clerk

Robert P. Harrison,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48773 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48773

CERTIFICATE OF DEATH. 91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1543 Friendship ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy May Walsh

(a) RESIDENCE. NO. Same ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3/18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jno E. Meal

11 BIRTHPLACE OF FATHER (city or town) Ky.
(State or country)

12 MAIDEN NAME OF MOTHER Eva M Owens

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Jno E. Meal
(Address) 1543 Friendship St.

15 Filed DEC 8 - 1920, 19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1920, to Dec. 7, 1920; that I last saw her alive on Dec. 7, 1920, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis foll. by Bronchopneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse foll. Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. A. Smith, M. D.

12/8, 1920 (Address) 1605 N. Monroe Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	DEC 10 1920
20 UNDERTAKER	ADDRESS
W. J. Ecknerd Sons	North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48774 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48774

CERTIFICATE OF DEATH. 120

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2849 W Lafayette ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Ward

(a) RESIDENCE. No. 2849 W. Lafayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Ward.

6 DATE OF BIRTH (month, day, and year) Feb. 9 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Williamsburg Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carroll E. Ward.

(Address) 2849 W. Lafayette Ave

15 Filed DEC 8 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Dec 7, 1920, that I last saw h alive on Dec 6, 1920, and that death occurred, on the date stated above, at 10 18a.m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

about 12 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) G. Lenoke Ewell. M. D.

Dec 8, 1920 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 9 1920
20 UNDERTAKER	ADDRESS
Wm J Tuckner & Sons	North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48775 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48775

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 W Fayette ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Zschiesche

(a) RESIDENCE. No. 2036 W. Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Robt. Zschiesche

6 DATE OF BIRTH (month, day, and year) 6/19/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg, Pa

PARENTS

10 NAME OF FATHER Edward Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Dietsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant W. E. Zschiesche

(Address) 2036 W. Fayette St. Balto Md.

15 Filed ....., 19 Robert F. Harrison, Registrar

DEC 8 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1920, to Dec 7, 1920, that I last saw he alive on Dec 6, 1920, and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J. M. Lumpkin, M. D.

1920 (Address) 826 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Dec 10 1920
20 UNDERTAKER	ADDRESS
W. J. Fickus & Son	N. Pa

• CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.48776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48776

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 E Cary - ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regena L Radenhi

Residence in Baltimore: No. 1311 E Cary St. St.; — yrs., — mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem'l	Wht	Single

6-DATE OF BIRTH, Dec 7, 1840
(Month) (Day) (Year)

7-AGE, — yrs. — mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James L Radenhi

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Reimer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L Radenhi

(Address) 1311 E Cary St

15-

DEC 8-1920 Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1920, to Dec 8 1920, that I saw h[illegible] alive on Dec 7 1920, and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Prolapsed Uterus

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edw Grant M. D.

12/8, 1920 (Address) 507 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Dec 9, 1920
20-UNDERTAKER	ADDRESS
Wm Fackler & Son	North Ave

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Emma J. Kelly

D.48777 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48777

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Kelly

(Residence in Baltimore: No. 345 Courtland St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Nov. (Month) 15 (Day) 1852 (Year)

7-AGE, 68 yrs. 0 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone cutter's wife
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John T Mumford

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Frazier

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Kelly

(Address) New York

15- DEC 8 - 1920 Robert P. Harrison,

Filed ..... 191.. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Cerebral Hemorrhage

Finding (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Daly M. D. (Coroner.)

Dec 8, 1920 (Address) 1637 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, 12/9, 1920

20-UNDERTAKER, Walter Davis — ADDRESS 3307 Pine St.

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048778 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048778

61-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 410 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Stevenson.

(a) RESIDENCE. NO. 1018 Hillman ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Camden, N. J.

PARENTS

10 NAME OF FATHER Frank Stevenson

11 BIRTHPLACE OF FATHER (city or town) Chila. (State or country) Pa.

12 MAIDEN NAME OF MOTHER Eva Hornstein

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Jack Lewis (Address) 1411 E Balto St

15 Filed DEC 9 - 1920 ROBERT B FRAZIER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1920, to Dec 7, 1920, that I last saw her alive on Dec 7, 1920, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Meningitis, epidemic

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) B MacDonald, M. D.

Dec 7, 1920 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/9 1920

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1048779 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048779

CERTIFICATE OF DEATH.

168

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 311 Whitridge St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice De Beer

(Residence in Baltimore: No. 167 W Belvedere St.: 4yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 17, 1876 (Month) (Day) (Year)

7-AGE, 44 yrs. 2 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Checker Oil
(b) General nature of industry, business, or establishment in which employed (or employer): Union News Co

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob De Beer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie R De Beer

(Address) 167 W. Belvedere Av

15- Filed DEC 9-1920, 191.. ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poisoning
Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

Dec 8, 1920 (Address) 3632 Roland Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park — DATE OF BURIAL, Dec 9, 1920

20-UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Av

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048780 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048780

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital WARD) 9

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boris Fedoruk

(a) RESIDENCE. No. Tolson Ave Balto Co. ST., ... WARD. Tolson Ave Balto Co.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 8 mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fedoruk

6 DATE OF BIRTH (month, day, and year) July 30, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	4	6	

8 OCCUPATION OF DECEASED 931

(a) Trade, profession or particular kind of work Machine Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sparrows Point

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Fedoruk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mary Fedoruk (Address) Tolson Ave Balto Co.

15 Filed DEC 9 - 1920 ROBERT I. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Dec. 6, 1920, that I last saw him alive on Dec. 6, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov 9. no.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec. 7, 1920 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Dec 9 1920
20 UNDERTAKER H. Wander Sons	ADDRESS 1710 Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

0648781 HEALTH DEPARTMENT—CITY OF BALTIMORE 0648781

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Linden Ave. ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah W. Caughy

(a) RESIDENCE. No. 1623 Linden Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 77 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 15, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John H. Caughy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Dixon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John H. Caughy
(Address) 1623 Linden Ave.

15 DEC 8 = 1920 ROBERT P. PRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 7 1920

17 I HEREBY CERTIFY, That I attended deceased from November 15, 1920, to Dec. 7. 1920,
that I last saw h[illegible] alive on Dec. 7. 1920,
and that death occurred, on the date stated above, at 12 [illegible] m.
The CAUSE OF DEATH* was as follows:

Cerebral Carcinoma

about 3
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of L. Breast removed Apr. 6. 1920.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Apr. 6. 1920

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, duration, etc.

(Signed) [illegible] M. D.

Dec 8, 19 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12/9/20 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state
information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48782 HEALTH DEPARTMENT—CITY OF BALTIMORE D48782

CERTIFICATE OF DEATH. 30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Haw ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malcom Wallace

(a) RESIDENCE. No. 637 Haw ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Fredrick Wallace

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Rainey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Fred Wallace
(Address) 637 N. Haw St

15 Filed DEC 9 - 1920 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 19 2, to Dec 6, 19 20,
that I last saw h alive on Dec 5, 19 20,
and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. mos. 1 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hans Byrd, M. D.

Dec 7, 19 (Address) 611 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn Cem Dec 9 1920

20 UNDERTAKER David Hendley — ADDRESS 578 N Eddie

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

L648783 HEALTH DEPARTMENT—CITY OF BALTIMORE L648783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 Waesche St., 4 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willis E. Birch

(Residence in Baltimore: No. 758 Waesche St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 2 (Month), (Day), 1864 (Year)

7-AGE, 56 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Q.R.

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosetta Birch

(Address) 758 Waesche St.

15- Filed DEC 9 - 1920, 191... ROBERT B KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1920, to Dec 9 1920, that I saw h im alive on Dec 6 1920, and that death occurred, on the date stated above, at 2.40 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 3 mos. ds.

(Signed) H. R. Hughes M. D.

12/7, 1920 (Address) 766 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 9, 1920

20-UNDERTAKER Samuel Hendley ADDRESS 518 N. Bond St.

N. B.—Every item in this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0 4 8 7 8 4 HEALTH DEPARTMENT—CITY OF BALTIMORE 0 4 8 7 8 4

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Sarah Ann ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phoebe Butler

(a) RESIDENCE. No. 605 Sarah Ann ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8th 86

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ella Bondon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Robinson

(Address): 335 Lamel St

15 Filed DEC 9-1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 29th 1920, to Dec 7th 1920, that I last saw her alive on Dec 7th 1920, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation (duration) 2nd mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) 2nd wk mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. F. Howell M. D.

1920 (Address) 767 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Caoses, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: David Hemsley

ADDRESS: 3[illegible] N Eddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Bronchitis

Not tuberculosis

Spec.—8-24-14—M. & T.—2000 Bks.

D48785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48785

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Lemmon St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mills

(Residence in Baltimore: No. 1507 Lemmon St.; .....yrs. .....mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Dec (Month) 6 (Day), 1920 (Year)

7-AGE, ...yrs. .....mos. 1 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None ///
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herbert Mills

11-BIRTHPLACE OF FATHER (State or Country), Howard County Md

12-MAIDEN NAME OF MOTHER Sadie Chase

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Mills (mother)

(Address) 1507 Lemmon St

15- DEC 9-1920 Filed....., 191.... ROBERT P. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 7 1920, that I saw her alive on Dec 7 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1 Prematurity

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. Morris Reed M. D.

Dec 7, 1920 (Address) Lemmon St. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. | DATE OF BURIAL, Dec 9th, 1920

20-UNDERTAKER C. Jones | ADDRESS 207 E Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D48786 HEALTH DEPARTMENT—CITY OF BALTIMORE D48786

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 208 S. Madeira ST. 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Duffy

(Residence in Baltimore: No. 208 S. Madeira St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 8th, 1920 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 10 hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andrew J Duffy

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Elenor Lynch

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew J. Duffy

(Address) 208 S. Madeira St

15- DEC 9 - 1920 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Finst Co M. D.

(Coroner)

12/8, 1920. (Address) 1501 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Dec 9th, 1920

20-UNDERTAKER Lilly & Gilder ADDRESS 403 S Wolfe St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48787

CERTIFICATE OF DEATH.

79

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Bank ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Portugal

(a) RESIDENCE. No. 1936 Bank ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1830

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 063

(b) General nature of industry, business, or establishment in which employed (or employer) Lithographer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Portugal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Casper A. Groth
(Address) 2502 Guilford ave

15 Filed DEC 9 — 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1920, to Dec 7th, 1920, that I last saw him alive on Dec 7, 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

OVER

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson, M. D.

Dec 7 1920 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 10th 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
Cardiac hypertrophy
for over a year.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Meinschein

no number D48788

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 D48788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 720 WARD)

2-FULL NAME Dolores Meinschein

(a) RESIDENCE. NO. 3707 Clairmont Ave ST., Balto Ind. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child ppp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md.
(State or country)

PARENTS

10 NAME OF FATHER George Meinschein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McKenna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J H Hospital Records
(Address)

15 Filed DEC 9-1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 19 20

17

I HEREBY CERTIFY, That I attended deceased from December 8, 1920, to December 8, 1920, that I last saw her alive on Dec. 8, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Fox, Jr. , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 9 1920
20 UNDERTAKER	ADDRESS
Henry Hoerdt Son	1301 E Eager

N. B.—BIRTH RECORD, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

2048789

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048789

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Warner St ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Neal

(Residence in Baltimore: No. Warner St Hollins St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, 10 (Month) 27 (Day) 1841 (Year)

7-AGE, 79 yrs. 1 mos. 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Louis Neal

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ollie Ware

(Address) Warner St Hollins

15- Filed DEC 9-1920, 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5- 1920, to Dec 3 1920, that I saw him alive on Dec 3 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ventricular Heart DBH
Pneumonia Acute

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Thos S Hall M. D.

Dec 7 1920 (Address) Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec. 9, 1920.

20-UNDERTAKER Edw. Ruggold — ADDRESS 1463 N Caren

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Prostate, cystic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 48790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48790

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 733 W. Lexington St. St.: 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McCarthy

(Residence in Baltimore: No. 733 W. Lexington St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Dont know

6-DATE OF BIRTH, Dont Know (Month), 1 (Day), ... (Year)

7-AGE, About 65 Years yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country). Dont Know

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country). Dont Know.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin J. Haycock

(Address) 715 N. Eutaw St.

15- Filed DEC 9 - 1920, 191... ROBERT A KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know if any

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Jones M. D. (Coroner.)

12-9-, 1920 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL, Dec 9, 1920

20-UNDERTAKER Chas. G. Black — ADDRESS 7424 Harford ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48791

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cairns

(a) RESIDENCE. No. 136 E Clement St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 11-20-20

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Harry K. Cairns

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Clayton

13 BIRTHPLACE OF MOTHER (city or town) Del
(State or country)

14 Informant University Hospital
(Address) Lombard & Eden Sts

15 Filed DEC. 9-1920 ROBERT J. KRAUTER Registrar
Burial Permit Out

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-8 1920

17

I HEREBY CERTIFY, That I attended deceased from 11-20, 1920, to 12-8, 1920,

that I last saw h[illegible] alive on 12-8, 1920,

and that death occurred, on the date stated above, at 1.23 A. M.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 11-20-20

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) F. V. Stoopes M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL	DEC 4 1920

20 UNDERTAKER JOHN F. DENNY

ADDRESS 716 LIGHT ST.

N. B.—WHITE PAPER, WITH CARBON ATTACHED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D48792 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48792

4022

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. Southern Hotel St. 4 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida W. Harwood

(Residence in Baltimore: No. 2598 7 St. New York. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 18, 1887
(Month) (Day) (Year)

7-AGE 32 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Diamond Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Ohio.

PARENTS.

10-NAME OF FATHER, Saul Horwitz.

11-BIRTHPLACE OF FATHER (State or Country) Austria

12-MAIDEN NAME OF MOTHER Bertha Rubler

13-BIRTHPLACE OF MOTHER (State or Country) Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice J. Schloss

(Address) 170 Broadway, N. Y.

15- ROBERT E KRAUTER

Filed DEC 9 1920, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis 1 yr.
Edema of Lungs 1 day
Edema of Glottis 12 hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred Edwin Blake M. D.
(Coroner.)

12/8/20, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New York City — DATE OF BURIAL, 12/9, 1920

20-UNDERTAKER Fahrenkrug & Co — ADDRESS 16 W Madison

Remarks

History of having examination for insurance three months ago. Turned down for albuminuria in urine. Probably chronic condition of kidneys

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner: *Deaths due to accident* (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

96 D 48793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 142 Spalding ave (ST.) (WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Virginia Schultz

(a) RESIDENCE. NO. 142 Spalding ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm McElwee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Freburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary C. Flannery

(Address) Bancroft Park

15 Filed DEC 9 - 1920 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Dec 7, 1920, that I last saw her alive on Jan 7, 1920, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Hemiplegia Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 142 Spalding ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. D. Cooper M. D.

19 (Address) Arlington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery Dec. 10 1920

20 UNDERTAKER, ADDRESS

John Ouletteelle 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48794 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48794

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2444 Jamietta ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Anna Turner

(a) RESIDENCE. No 2444 Jamietta ave ST., 20 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mln.
	73	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm H. E. Turner

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Hester Ann Rusk

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Marshall W. Shields
(Address) 2444 Jamietta ave

15 Filed ..... 19 Robert P. Harrison Registrar

DEC 9-1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23 1920 to Dec 7th 1920

that I last saw her alive on Dec 7 1920

and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Lobular Pneumonia

Cardiac Dilatation & Exhaustion (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) Thomas J Talbott M. D.

1920 (Address) Marlborough & Eph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glen Mount Cemetery	Dec 10 1920
20 UNDERTAKER	ADDRESS
Jas. Kehoe & Son	2503 Edmondson ave

PHYSICIANS should be stated EXACTLY, and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48795 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48795

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatius Bannok

(a) RESIDENCE. No. 703 S. Wolfe St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Bannok

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed DEC 9-1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 6, 1920, to December 7, 1920, that I last saw him alive on December 6, 1920, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocardial insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) V. Stutzman, M. D.

12/7/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 9 - 1920 19
20 UNDERTAKER	ADDRESS
Commissioner Health.	

Per. Wm. E. WOODALL

A. B.—WHITE LEAVES, WITH CARBON BETWEEN, FOR PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48796

CERTIFICATE OF DEATH.

82-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Iannallo

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital JOHNS

15 Filed DEC 9 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1920

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1920 to December 7, 1920, that I last saw h. im alive on December 7, 1920, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis with cerebral thrombosis.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) V. B. Sherman, M. D.

12/8/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	DEC 9 - 1920
20 UNDERTAKER Commissioner Health.	ADDRESS

Per. Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48797 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48797

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 Druid Hill av ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ward

(a) RESIDENCE. No. 433 D Hill av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state EXACTLY, WHERE DISEASE HAS BEEN CONTRACTED, IF NOT AT PLACE OF DEATH. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) 11/27/20

7 AGE — Years — Months — Days 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chesterfield Md

12 MAIDEN NAME OF MOTHER Bessie Holden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alma Va

14 Informant Daniel Ward (Address) 433 D Hill

15 Filed DEC 9 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/27 1920, to 12/9 1920, that I last saw h alive on 12/8 1920, and that death occurred, on the date stated above, at 7.30A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D.

19 (Address) 1518 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL. DATE OF BURIAL: DEC 9 - 1920 19

20 UNDERTAKER: Commissioner Health, ADDRESS

Per. Wm E. WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48798

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100-3rd Ave., E. Brooklyn, ST.; 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Matucak

(a) RESIDENCE. NO. 100-3rd Ave., E. Brooklyn ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? 14 yrs. 7 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White. Poland.

5 Single, Married, Widowed, or Divoreed (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Michael Matucak

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	(?)	(?)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife (?)

(b) General nature of Industry, business, or establishment in which employed (or employer): Home duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Frank Sulsinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Thos. Michael Matucak

(Address) 100-3rd Ave. E. Brooklyn.

15 Filed DEC 9 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1920, to Dec. 8th, 1920, that I last saw h[illegible] alive on Dec. 6th, 1920, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation preeede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] Dr. M. D.

Dec 8. 1920 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross M & Co	Dec 11 1920
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48799 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48799

CERTIFICATE OF DEATH. 132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St.; 13 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Etta Redding

(a) RESIDENCE. No. 3623 Cedar Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state EXACT statement of OCCUPATION should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE: 25 Years; Months: do not know; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Worked in Mill

(b) General nature of industry, business, or establishment in which employed (or employer): do not know

(c) Name of employer: " " "

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): — " "

12 MAIDEN NAME OF MOTHER: " — "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): — " "

14 Informant: Mrs Minnie Heyn

(Address) 3623 Cedar Ave.

15 Filed DEC 9-1920 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-6, 1920, to 12-8, 1920, that I last saw her alive on 12-8, 1920, and that death occurred, on the date stated above, at 10.55 P m.

The CAUSE OF DEATH* was as follows:

Salpingitis + peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-8-20

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Will C Reany, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery Baltimore Co Md — DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: W M Routson — ADDRESS: 230 N Green

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48800 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48800

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 4322 Eastern ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Neal

(a) RESIDENCE. No. 4322 Eastern ave ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 - 1920

7 AGE — Years: — Months: — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ———

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John T. Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Carrie Henthorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John T. Neal 3723 Eastern ave

15 Filed DEC 9-1920

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 24th, 1920, to Dec 8th, 1920, that I last saw her alive on Dec 7th, 1920, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) adam Jos ....., M. D.

, 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: J Herwig & Co — ADDRESS: 2008 Aliceanna

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

1048801 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048801

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 510 Scott St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agness Mathews

(Residence in Baltimore: No. 517 Scott St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 5 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, VaughnMathews

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Irene Seible

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vaughn Mathews

(Address) 510 Scott St

15- DEC 10 1920 ROBERT B KRAUTER

Filed ....., 191... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8th 1920, to Dec 9 1920, that I saw her alive on Dec 8 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

0 DW

Irritation of Brain

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Eden Brumbaugh M. D.

12.9.20, 191... (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, DEC 15, 1920

20-UNDERTAKER Geo Leinbach & Sn ADDRESS 6774 Frankford Ave

N. B.—Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048802 HEALTH DEPARTMENT—CITY OF BALTIMORE 20·48802

CERTIFICATE OF DEATH. +39

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospl. St.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doctor S. L. Helm

(a) RESIDENCE. NO. Lexington, Ky. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Maud Helm

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED 054

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) do not know

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know " "

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know " "

14 Informant Mrs S. L. Helm (Address) Lexington Ky.

15 DEC 10 1920 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1920, to Dec. 9, 1920, that I last saw him alive on Dec. 9, 1920, and that death occurred, on the date stated above, at 6:50 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General infection due to multiple thrombi (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-2-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. C. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LEXINGTON, KENTUCKY	DEC 12 1920
20 UNDERTAKER	ADDRESS 175 CALHOUN
Robt Burks & Son Co.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sue Cheatam

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948803 1948803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 14 WARD)

REGISTERED NO. 82

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sue Cheatam

(a) RESIDENCE. NO. 1421 Mt. Royal Ave ST., WARD. Danville

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Charles Duncan

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sally Wright

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mercy Hosp
(Address) Mercy Hosp

15 DEC 10 1920 ROBERT E LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/1 1920, to 12/9 1920, that I last saw h alive on 12/9 1920, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Wm D. Rodgers, M. D.

12/9 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Danville Va	12/10 1920

20 UNDERTAKER George A Lindy Sellers & Tyson ADDRESS —

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gilbert

1948804 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948804

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 Strickland ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Gilbert

(a) RESIDENCE. NO. 3226 Strickland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gilbert

6 DATE OF BIRTH (month, day, and year) Aug 4. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54.	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Frederick Ames

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. J. Sheeler (Address) 3226 Strickland St

15 Filed DEC 10 1920 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1920

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to Dec 8, 1920, that I last saw h[illegible] alive on Dec 7, 1920, and that death occurred, on the date stated above, at 1. P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Howard Jones, M. D.

19 (Address) Dec 8. [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	12/10/20
20 UNDERTAKER Geo A Fahey Fulton St	ADDRESS Fayette

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048805 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048805

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S Bonaldin ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Schumans.

(a) RESIDENCE. No. 700 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-1920

7 AGE: Years | Months: 10 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Edward Schumans.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Elizabeth Zapf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Edward L. Schumans
(Address) 700 S. Bouldin

15 FILED DEC 10 1920 ROBERT B. KRAUTER Registrar
Burial Permit Issued Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920.

17 I HEREBY CERTIFY, That I attended deceased from 11/20, 1920, to 12/7, 1920, that I last saw h.e alive on 12/7/20, 19..., and that death occurred, on the date stated above, at 7.40 p.m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Garrell, M. D.

, 19 (Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Front Ave	Dec 10 1920
20 UNDERTAKER	ADDRESS
Mendel Stapleton	1 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48806 HEALTH DEPARTMENT—CITY OF BALTIMORE D48806

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Virginia Line Grimes St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Cayanna

(Residence in Baltimore: No. Grindon Lane & Herring Run St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Mar 7th, 1901 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
19 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chocolate
(b) General nature of industry, business, or establishment in which employed (or employer)..... Piper 186

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Louis Cayanna

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Margaret Peralena

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Cayanna

(Address) Grindon Lane & Herring Run

15-

Filed DEC 10 1920 ROBERT J. KRAUTER

Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from [redacted] 6 1920, to Dec 8 1920, that I saw h[redacted] alive on Dec 6 1920, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) [redacted] M. D.

Dec 10, 1920 (Address) [redacted]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Timothy	Dec 12, 1920
20-UNDERTAKER	ADDRESS
Randall Hoppe & Son	[redacted]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48807 HEALTH DEPARTMENT—CITY OF BALTIMORE D48807

CERTIFICATE OF DEATH.

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John A Steffen Hospital St. 15 WARD)

2-FULL NAME Robert Charles Redding

(a) RESIDENCE. No. 2009 Walbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Rob. M Redding

11 BIRTHPLACE OF FATHER (city or town) Prentiss
(State or country) Miss

12 MAIDEN NAME OF MOTHER E Winchester Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Rob. M. Redding
(Address) 2009 Walbrook Ave

15 Filed DEC 10 1920 ROBERT J. SLATTERY Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1920, to Dec 9, 1920, that I last saw h[illegible] alive on Dec 9, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2009 Walbrook

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Slaughter, M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	12-10 1920
20 UNDERTAKER H. C. Brauning & Son	ADDRESS 517 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48808 HEALTH DEPARTMENT—CITY OF BALTIMORE D48808

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Fells Road ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar F. Scott. Jr.

(a) RESIDENCE. NO. 203 Fells Road ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edgar F Scott.

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara McKenny

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania
(State or country) Pa

14 Informant Ed. Scott
(Address) 703 Fall Road Roland Park

15 Filed DEC 10 1920 ROBERT b LEANTES Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 10, 1920, that I last saw h alive on Dec 9, 1920, and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Premature child
Simply lived 48 hrs
live!

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Infection of Child

(Signed) Ed D Norment M. D.

. 19 (Address) 35-47 Cheapside Bc

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 10 1920

20 UNDERTAKER A J Marshall ADDRESS 353 Fall Rd

IMPORTANT—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D48809 HEALTH DEPARTMENT—CITY OF BALTIMORE D48809

CERTIFICATE OF DEATH.

REGISTERED NO. 99

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2827 Alameda Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Mary Slotke

(a) RESIDENCE. No. 2827 Alameda Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (or) WIFE of: John D. Slotke

6 DATE OF BIRTH (month, day, and year): June 28 68

7 AGE: Years 52 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Fred. Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John D. Slotke
(Address): 2827 Alameda ave

15 Filed DEC 10 1920 By ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Dec 8, 1920, that I last saw h[illegible] alive on Dec 7, 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bright's disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. F J Kinzer, M. D.

Dec 10, 1920 (Address) 1700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D48810 HEALTH DEPARTMENT—CITY OF BALTIMORE D48810

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 E Monument St. WARD)

2-FULL NAME Henry Theodore Schaaf

(Residence in Baltimore: No. 1015 E. Monument St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Oct 22nd (Month) (Day), 1875 (Year)

7-AGE, 45 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Fred. Schaaf

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schaaf

(Address) 2007 Orleans

15- Filed DEC 10 1920 ROBERT P. LAMOTTE Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Knox Grinder M. D. (Coroner)

12-10 1920 (Address) City Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Dec 10 1920
20-UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48811 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48811

CERTIFICATE OF DEATH. 26

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital - ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. Morris

(a) RESIDENCE. No. 126 Jackson Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Sadie Morris

6 DATE OF BIRTH (month, day, and year) c. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mason Work.

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Cary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Hospital Records
(Address)

15 Filed DEC 10 1920 19 ROLLEY E. KALOTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Dec 7, 1920, that I last saw him alive on Dec 7, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Ulcerative colitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) U. R. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nancock Va	Dec 10 1920
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 N Bway

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48812

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Clifton Place ST.: 8 WARD)

2-FULL NAME Moses T. Hoopes

(a) RESIDENCE. No. 1621 Clifton Place ST., 8 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? Pennsylvania yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Hoopes

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bridge walker

(b) General nature of industry, business, or establishment in which employed (or employer): None for 3 yrs

(c) Name of employer: Penn R.R. Co

9 BIRTHPLACE (city or town) (State or country): Cecil Co Md.

PARENTS

10 NAME OF FATHER Frank Hoopes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co Md.

12 MAIDEN NAME OF MOTHER Mary Weir

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co Md.

14 Informant (Address): Frank Hoopes 621 Clifton Blvd

Filed DEC 10 1920 ROBERT P. CHAPLEAU Registrar

Harold Powell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec. 6, 1920.

That I last saw him alive on Dec. 5, 1920,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

CONTRIBUTORY (Secondary): Cerebral apoplexy (duration) 4 yrs. mos. ds.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted, if not at place of death? At Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. C. Burnbark, M. D.

(Address) 1531 E. Northane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury M. E. Cem Perryville Md. DATE OF BURIAL 12/10/1920.

20 UNDERTAKER: George J. Tuth ADDRESS 1735 Hanford Ave

should be stated EXACTLY. PHYSICIANS should state PLAINLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1650 Cliftview av ST.; 8 WARD) 170

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pancoast

(a) RESIDENCE. No. 1650 Cliftview av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Pancoast

6 DATE OF BIRTH (month, day, and year) Feb. 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69.	9	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER John Pancoast

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Marie Winchester

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Bungs (Address) 1650 Cliftview av.

15 Filed DEC 10 1920 ROBERT E LEE TYLER Registrar

Burial Permit Oliark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 8, 1920, that I last saw him alive on Dec 7, 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Uraemic Toxaemia

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B. F. Herzog MD M. D.

Dec 9, 1920 (Address) 1305 N Patterson Pk Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec. 10, 1920
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1460 Battery Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48814 HEALTH DEPARTMENT—CITY OF BALTIMORE. D48814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Powson ST.: 24 WARD) 28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Powolskin

(a) RESIDENCE. NO. 1424 Powson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Richard C. Powolskin

6 DATE OF BIRTH (month, day, and year) Oct 24 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas. Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Katherine Snyder 1424 Powson St.

15 Filed DEC 10 1920 ROBERT B. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Dec 8 1920

that I last saw h[illegible] alive on Dec 8 1920

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuber-
culosis 1 yrs. — mos. — ds.

(duration)

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) A. Kaufmann, M. D.

19 (Address) 1340 E Chase

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Dec. 10 1920
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1432 Light St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state at it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48815 HEALTH DEPARTMENT—CITY OF BALTIMORE D48815

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. West ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Sullivan

(a) RESIDENCE. No. 26 E. West ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	26	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jos. Gutman Co.

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Rodolph Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Anna Sullivan (Address) 26 E. West St.

15 Filed DEC 10 1920 ROBERT B. ... Registrar

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Dec 7, 1920, that I last saw h alive on Dec 7, 1920, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Hammond Lee M. D.

Dec 8 1920 (Address) 831 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Dec. 11 1920

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Eight St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations should be carefully avoided. ALL should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Geo. W. Fefel

D48816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48816

CERTIFICATE OF DEATH.

92-010

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Christian St St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Fefel

(Residence in Baltimore: No. 1900 Christian St St.; 39 yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 20, 1881.
(Month) (Day) (Year)

7-AGE, 39 yrs. mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce 045
(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George W. Fefel

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Barbara A. Fell

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary R. Fefel

(Address) 1900 E. Christian St.

15-

Filed DEC 1 01920, 191.... ROBERT P. KRAUTER Registrar.

Burial Permit 6553

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 7, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1920, to Dec 7 1920, that I saw him alive on Dec 7 1920, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Dysentery & Colon
Tuberculosis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

Tuberculosis (Duration) yrs. mos. 2 ds.

(Signed) Robert C. Slater M. D.

Dec 8, 1920 (Address) 3151 Whitelock ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 10..., 1920

20-UNDERTAKER, Geo. W. Schwab & Bro — ADDRESS 2101 Eutaw ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

048817

HEALTH DEPARTMENT—CITY OF BALTIMORE

048817

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3131 Wilkens Ave, ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Jeske

(a) RESIDENCE. No. 3131 Wilkens Ave STR. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma H. Jeske

6 DATE OF BIRTH (month, day, and year) Sept 4, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41 yrs.	3	3	

006

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of Industry, business, or establishment in which employed (or employer) Iron works

(c) Name of employer Bartlett Haywards Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas F Wadman

(Address) 731 S. Smallwood

15 Filed DEC 10 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7th 1920,

17 I HEREBY CERTIFY, That I attended deceased at from different times during last 3 years, dates intervening, to ....., 19....., that I last saw h.....alive on....., 19....., and that death occurred, on the date stated above, at about 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Several years

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical manifestations

(Signed) J. Frederick Hempel, M. D.

Dec 9, 1920 (Address) 3310 W. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 11 1920
20 UNDERTAKER Geo. W. Little	ADDRESS 731 N. Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Issued

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48818

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 521 S Collington Ave. 1 WARD)

2-FULL NAME Bruna Pope

(a) RESIDENCE. No. 521 S Collington Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 29 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Earnest Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia Varcko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Julia Pope (Address) 521 S Collington Ave

15 Filed DEC 10 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1920, to Dec 10 1920, that I last saw h— alive on Dec 9 1920, and that death occurred, on the date stated above, at 1 30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar - Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Jno R Donaldson, M. D.

12/12 1920 (Address) 125 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Dec 11 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Flat St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48819

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 S. Eden ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria M. Groschboth

(a) RESIDENCE. No. 326 S. Eden ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of Henry Groschboth

6 DATE OF BIRTH (month, day, and year) March 22, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Krawich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Groschboth (Address) 326 S. Eden St

15 Filed DEC 10 1920, 19 ROBERT E. LEE Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17 I HEREBY CERTIFY, That I attended deceased from July - 10, 1920, to Dec - 9 -, 1920, that I last saw h.r alive on Dec 8 -, 1920, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver —

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) General Debility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

19 (Address) 125 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 13 1920
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1060 Bks.

D48820 HEALTH DEPARTMENT—CITY OF BALTIMORE D48820

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH E.

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2820 Monument St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J Sturmfels

(a) RESIDENCE. No. 2828 Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Sturmfels

6 DATE OF BIRTH (month, day, and year) Jan 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rice Bros.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Sturmfels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Maaser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Sturmfels

(Address) 2820 Monument St

15 Filed DEC 10 1920 19 ROBERT I. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28 1920, to Dec. 9, 1920, that I last saw h alive on Dec. 9, 1920, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Senral Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray Examination

(Signed) Chas J Schmit, M. D.

12/9/1920 (Address) 701 N Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cemetary	Dec 11 1920
20 UNDERTAKER	ADDRESS
H. Vandeveer Son	1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

144855 2048821

HEALTH DEPARTMENT—CITY OF BALTIMORE 2048821

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.; W WARD)

2-FULL NAME Ceory Makowska.

(a) RESIDENCE. NO. 528 South Ann st ST., City. WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married (separated)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Makowski.

6 DATE OF BIRTH (month, day, and year) Dec 24-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47		9	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Johns Hopkins Hosp Records (Address)

15 Filed ..... 19 ..... Registrar

DEC 10 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 ....., 1920, to Dec 9 ....., 1920, that I last saw h Ever alive on Dec 9 ....., 1920, and that death occurred, on the date stated above, at 0220 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal acidosis

(duration) ..... yrs. ..... mos. 1½ ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine + blood CO2

(Signed) Edward C. Davidson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Dec 13" 1920
20 UNDERTAKER M. F. Sadowski	ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D48822

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D48822

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 815 Augusta St.; 10 WARD)

2-FULL NAME Estella Bernard

(Residence in Baltimore: No. 815 Augusta St.; 63 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fml

4-COLOR OR RACE, colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1857 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) House Work

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Lance R Colter

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane Rudgent

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Lawrence Colter

(Address) 1045 Fulford ave

15-

Filed DEC 10 1920 191.....

ROBERT B BEAUTER

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 8 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: 0720

Diabetes Mellitus

4 yrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Harford Rd — DATE OF BURIAL, Dec 11, 1920

20-UNDERTAKER John J Cavan & Son — ADDRESS 921 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Accidental

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48823

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1807 Barclay St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice A Wiltman

(a) RESIDENCE. NO. 1807 Barclay. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPA-

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Wiltman

6 DATE OF BIRTH (month, day, and year) Nov 6 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Goodhand

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Angelina Oldham

13 BIRTHPLACE OF MOTHER (city or town) Fell Tenn.
(State or country)

14 Informant Grace
(Address) 1807 Barclay St

15 Filed 19 Robert P. Harrison Registrar

DEC 10 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1903, to Dec 8th 1920, that I last saw h[er] alive on Dec 7th 1920, and that death occurred, on the date stated above, at 9.8 m.

The CAUSE OF DEATH* was as follows: over

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Loss of motion

(Signed) Wm W Wiltman, M. D.

, 19 (Address) 1801 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 11 1920
20 UNDERTAKER	ADDRESS
E A Windfield Jr &	501 E 22nd St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48824

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48824

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Forest Place St. 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Macklin

(Residence in Baltimore: No. 1021 Forest Place St.; 81 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, October 9th, 1839
(Month) (Day) (Year)

7-AGE, 81 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nothing
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, John Macklin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Corrigan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. H.B. Saunders

(Address) 719 E. Preston St.

15- Filed DEC 10 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9th 1919, to Dec 9th 1920, that I saw him alive on Dec 9th 1920, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

..... (Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Bronchitis

..... (Duration) 2 yrs. mos. ds.

(Signed) Joseph B. Saunders M. D.

Dec 10th, 1920 (Address) 719 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents DATE OF BURIAL, Dec 13., 1920

20-UNDERTAKER H.C. Widefeld ADDRESS 914 Greenmount Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48825 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48825

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 W 29th St. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Blake

(a) RESIDENCE. No. 408 W 29th St. 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm F Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Grace Blake (Address) 408 W 29 St

15 Filed DEC 10 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 10, 1920, that I last saw h[illegible] alive on Dec 9, 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Hemolytic Anemia

7 months, 4 days to live.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Inspection of child

(Signed) R S Norment, M. D.

, 19 (Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 10 1920

20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48826 ✓ D. 48826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St.: 26 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas E Bailey

(a) RESIDENCE. No. 3104 Fairmount Ave. St.: Ward. 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Miller Bakery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frank Co Md

PARENTS

10 NAME OF FATHER Charles E. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Elizabeth McLaughry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie F Bailey

(Address) 3104 Fairmount Ave

15 Filed Dec 12 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to Dec 9, 1920, that I last saw her alive on Dec 9, 1920, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) several days

CONTRIBUTORY (Secondary) Fatty Infiltration of Viscera (duration) Due work yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 5.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) St Josephs Hosp Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Dec 13 1920
20 UNDERTAKER	ADDRESS
A S Mass Hill	2539 Fell St

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48827 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48827

CERTIFICATE OF DEATH. X 172

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ashley F. Sutherland

(Residence in Baltimore: No. 522 Park Heights Ave, St.; yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, October (Month) (Day) 1900 (Year)

7-AGE, 20 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

086

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tree surgeon
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Davey Tree Expert Co.)

9-BIRTHPLACE, (State or Country), Ohio Maine

PARENTS.

10-NAME OF FATHER, Mulvaney

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Foster

(Address) 603 American Bldg. Balto.

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental, Compound fracture both arms, simple fracture right femur (fell from tree)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) J. D. Hemmeter M. D. (Coroner.)

Dec. 10, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos. 6 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?..... Reisterstown, Md.

Former or usual residence Kent, Ohio.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Caribou Maine	Dec 16, 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 103 Saratoga St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48828 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Pronounced dead — 175-001 — REGISTERED NO. C.....

CITY OF BALTIMORE (No. St Agnes Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franklin C. Van Horn

(Residence in Baltimore: No. 2345 McElderry St.; yrs. 75 mos. ds.)

CAUSE OF DEATH should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state AGE should be carefully applied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... Nov (Month) 18 (Day), 1875 (Year)

7-AGE, 45 yrs. ..... mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Auto salesman
(b) General nature of industry, business, or establishment in which employed (or employer): D&C

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Coleman Van Horn

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louisa Hutchins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis B. Van Horn

(Address) 2345 McElderry St

15- DEC 10 1920 1920 Robert P. J. Harrison Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compression of chest by being caught in overturned auto & driving wheel pillar in chest

Auto accident (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton (Coroner.) M. D.

12-7, 1920 (Address) 700 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Washington Rd

Former or usual residence 2345 McElderry St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Dec 10, 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48829

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Taylor

(Residence in Baltimore: No. Belair and Joppa Rd St.; yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept (Month) 8 (Day) 1851 (Year)

7-AGE. 69 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. Taylor

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Elsie Taylor.

(Address) Fullerton, Md.

15-

Filed DEC 10 1920 Robt. P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/4 1920, to 12/10 1920, that I saw h~ alive on 12/10 1920, and that death occurred, on the date stated above, at 5 p~ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(Duration) yrs. mos. ds.

(Signed) Thos Elsie M. D.

12/9, 1920 (Address) Mendenhall Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Belair & Joppa rd

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Dec 10, 1920.

20-UNDERTAKER Joseph B. Cook — ADDRESS 1005 W Baltimore St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48830 HEALTH DEPARTMENT—CITY OF BALTIMORE D48830

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2663 Wilkens ave ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J. Shaw

(Residence in Baltimore: No. 2663 Wilkens ave St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 15, 1842
(Month) (Day) (Year)

7-AGE, 78 yrs. 8 mos. 24 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore md

PARENTS.

10-NAME OF FATHER, Michael Sweeney

11-BIRTHPLACE OF FATHER (State or Country), America

12-MAIDEN NAME OF MOTHER Jane Duffy

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. C. Shaw

(Address) 2663 Wilkens Ave

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

DEC 10 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Dec 9 1920, that I saw h[illegible] alive on Dec 9 1920, and that death occurred, on the date stated above, at 4.05 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

Duration ..... yrs. mos. 2 ds.

(Signed) Robert K Cruter M. D.

Dec 9, 1920 (Address) 2450 Shelburne ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem | DATE OF BURIAL, Dec 13, 1920

20-UNDERTAKER Joseph P Cook | ADDRESS 1003 N Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48831 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St., 120 Ward)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Sommer

(a) RESIDENCE. No. Colgate Station, Balto, Md St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Sommer.

6 DATE OF BIRTH (month, day, and year) ? 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Farmer. Hand.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Harry B. Stengel

9 BIRTHPLACE (city or town) (State or country) France.

PARENTS

10 NAME OF FATHER John Sommer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

14 Informant Harry B. Stengel.
(Address) Colgate Md.

15 Filed DEC 10 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1920, to Dec 9, 1920, that I last saw him alive on Dec. 8, 1920, and that death occurred, on the date stated above, at 5 20 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S.W. Kourey M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Point Church. Cem,	Dec. 11 1920
20 UNDERTAKER Lilly and Zirkin.	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48832

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1109 S. Second St. St.: 26 Ward)

2-FULL NAME Elizabeth M. Rettkowske.

(a) RESIDENCE. No. 1109 S. Second St. St., 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry H. Rettkowske.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Joseph Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry H. Rettkowske
(Address) 1109 S. Second St.

15 Filed DEC 10 1920

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7th 1920

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to Dec 7, 1920, that I last saw her alive on Dec 7, 1920, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) M. D.

12/9. 1920 (Address) Horace B Tilson MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cem.	Dec. 11 1920
20 UNDERTAKER	ADDRESS
Lilly and Zeiler.	403 S. Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48833 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48833

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 Salem Av ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alvina Wagner

(Residence in Baltimore: No. 2517 Salem Av St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 12th, 1890 (Month) (Day) (Year)

7-AGE, 30 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... (3)

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Karl Kraus

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Frida Diener

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Wagner

(Address) 2517 Salem Av

15-

Filed DEC 10 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1920, to Dec 7" 1920, that I saw h e alive on Dec 7th 1920, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) 1 yrs. ..... mos. 3 ds.

(Signed) Thomas L. Talbott M. D.

Dec 9, 1920 (Address) 1 Marlborough Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec 11, 1920

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hayford Ave.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48834 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48834

CERTIFICATE OF DEATH.

74

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N Robinson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo M. Laynie

(a) RESIDENCE. NO. 525 N Robinson ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) July 25 1901

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Layne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Annie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Annie Layne

(Address) 525 N Robinson St

15 Filed DEC 10 1920 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1920

17

I HEREBY CERTIFY, That I attended deceased from June 4 1920, to Dec. 8 1920, that I last saw him alive on Dec 7 1920, and that death occurred, on the date stated above, at 12 p m.

The CAUSE OF DEATH* was as follows:

Chronic Talvula Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 402 N Robinson

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D J Herzog M D M. D.

Dec 9. 1920 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 11 1920
20 UNDERTAKER	ADDRESS
Edward Conditt & Eager	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48835 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48835

CERTIFICATE OF DEATH.

REGISTERED No. C 164

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1703 Ashburton St. (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine C. Edwards

(Residence in Baltimore: No.) 1703 Ashburton Ave (St.) 23 yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): Single

6-DATE OF BIRTH: Nov. 28, 1847 (Month) (Day) (Year)

7-AGE: 73 yrs. mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Ft. Ds. Md.

PARENTS.

10-NAME OF FATHER: R. C. Edwards

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Rhoda E. Dandridge

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Edwards

(Address) 1703 Ashburton Ave

15-

Filed DEC 10 1920, 191

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 7, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Senility (Duration) 3 yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 10, 1920 (Address) 2802 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Mt. Hope Hosp.

Former or usual residence 1703 Ashburton Ave

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Dec. 11, 1920

20-UNDERTAKER: Wm. J. Tretner & Sons ADDRESS: North & Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48836 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48836

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Holland

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	~~Single~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed DEC 11 1920, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1920

17 I HEREBY CERTIFY That I attended deceased from February 7, 1919 December 8, 1920, that I last saw her alive on December 8, 1920, and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH was as follows:

Arteriosclerosis and cerebral thrombosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) R. H. Hedman M. D.

12/9/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W.M. Auburn	Dec. 1/ 1920
20 UNDERTAKER	ADDRESS
John H. Toadvine	1472 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48837

CERTIFICATE OF DEATH.

24 28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. ..... WARD)

2-FULL NAME John C. Wheeler

(a) RESIDENCE. No. 1343 Cooksie St. (Locust Point) ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Wheeler

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline V. Waltham

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 11 1920, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1920, to Dec. 9, 1920, that I last saw him alive on Dec. 9, 1920, and that death occurred, on the date stated above, at 7.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Algire, M. D.

12-10-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 13 1920
20 UNDERTAKER Geo Mosset	ADDRESS 1442 N Gay

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48838 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48838

CERTIFICATE OF DEATH.

104

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 715 W. Mulberry St. ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esta Blair

(Residence in Baltimore: No. 715 W. Mulberry St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, June 11, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, James Black

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Blair

(Address) 715 W. Mulberry St

15-

Filed ....Robert P. Harrison, 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Trouble

(Duration) yrs. 5 mos. ds.

(Signed) W. R. Gorman M. D. (Coroner.)

12-10.., 1920 (Address) 11 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of denth ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Dec 11, 1920
20-UNDERTAKER Daniel Earles	ADDRESS 916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

[Postal Permit Clerk]

Spec. -6-9-19—H. P. Co.—1000 Blks.

D.48839 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048839

CERTIFICATE OF DEATH. 37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 George ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Jackson

(a) RESIDENCE. No. 612 George ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Douglass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rebecca Green
(Address) 612 George St

15 Filed DEC 11 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Dec 10, 1920, that I last saw her alive on Dec 9, 1920, and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Myelitis

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Neuritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Cooney, M. D.

, 19 (Address) 733 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Dec 13 1920
20 UNDERTAKER Daniel Eccleston	ADDRESS 906 Pennsylvania

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer, Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Specific

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48840

CERTIFICATE OF DEATH.

102

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Seibold

(a) RESIDENCE. NO. 764½ Saratoga St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Michael H. Seibold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E. Miller

13 BIRTHPLACE OF MOTHER (city or town) [redacted]
(State or country) Germany

14 Informant Hospital Records
(Address) Balto Md

15 Filed DEC 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 28th 1920, to Dec 10 1920,

that I last saw him alive on Dec 10th 1920,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) ? 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro-Intestinal Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Dec 1st

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Holmann, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL	DATE OF BURIAL
Greenmount	Dec 13 1920
20 UNDERTAKER	ADDRESS
Geo W Little	631 N Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-malignant

Spec.—8-24-14—M. & T.—2000 Blks.

Fullenkamp

D.48841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE; (No. 421 Gilmor ST.; 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B Fullenkamp

(Residence in Baltimore: No. 421 S Gilmor St.; 69 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W	Widower

6-DATE OF BIRTH, ... May (Month) 19 (Day) 1857 (Year)

7-AGE, 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H Fullenkamp

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Wendekamp

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fullenkamp

(Address) 421 S. Gilmore St

15-

Filed ..... OCT 1 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to Dec 10 1920, that I saw h[illegible] alive on Dec 9 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Jas E Inness M. D.

Dec 10, 1920 (Address) 1530 W Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Dec 13, 1920

20-UNDERTAKER John J Fields

ADDRESS 1700 N Lombard st

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48842 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington St. 15 WARD) REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. F. P. Malehorn — (Frank)

(a) RESIDENCE. NO. 623 Cumberland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Carroll Co Md.

PARENTS

10 NAME OF FATHER John Malehorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Maryland

12 MAIDEN NAME OF MOTHER Lydia Barr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Carroll Co Md.

14 Informant Martha E. Malehorn
(Address) 623 Cumberland St.

15 Filed DEC 11 1920, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1920, to Dec. 10, 1920, that I last saw him alive on Dec. 10, 1920, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:
Chronic (T. B.) Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 623 Cumberland

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. Y. Test.

(Signed) J. L. Lafayaud, M. D.

, 19 (Address) 418 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Dec 13 1920
20 UNDERTAKER L. M. Gallhurst	ADDRESS 1624 Mc Elderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48843 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48843

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Mills

(a) RESIDENCE. No. 1815 N. Orleans St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland Balto (State or country)

PARENTS

10 NAME OF FATHER Tom Smith

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Laura Blake

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed ..... 19.. Robert P. Harrison, Registrar

DEC 11 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from November 22, 1920, to December 8, 1920, that I last saw h.. alive on December 8, 1920, and that death occurred, on the date stated above, at 8:00 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse carcinomatosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) N Bottleman M. D.

12/9/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 11 1920
20 UNDERTAKER	ADDRESS 1725
M M Root & Elliott	Arlington

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48844

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 N Montford Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Demmell

(a) RESIDENCE. No. 841 N Montford ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amy Demmell

6 DATE OF BIRTH (month, day, and year): Nov 7, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Emma Pfeffer
(Address): 841 N Montford Ave

15 Filed: Robert P. Harrison, Registrar

FEB 11 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to Dec 9, 1920, that I last saw h.w alive on Dec 8 1920, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Int Nephritis

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) A B Fleischer, M. D.

2/11/1919 (Address) 718 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 11 1920
20 UNDERTAKER	ADDRESS
J. Conway & Son	Fort Allegany

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48845 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48845

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Edmondson ave. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Wallace

(a) RESIDENCE. NO. 1031 Edmondson Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Wallace

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 061 Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wicklow Co. Ireland

12 MAIDEN NAME OF MOTHER Eliza Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queens Co. Ireland

14 Informant Florence D. Wallace (Address) 1031 Edmondson Avenue

15 Filed DEC 11 1920, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9/1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Dec 9, 1920, that I last saw him alive on Dec 9, 1920, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Myocarditis & Nephritis

"Senility"

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Repeated Examination

(Signed) J. F. O'Mara, M. D.

, 19 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	12-13 1920
20 UNDERTAKER Henry W. Jenkins Sons Co	ADDRESS Orchard & Mcculloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48846

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 721 Argyle Ave ST.; 17 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Johnson

(Residence in Baltimore: No. 921 Argyle Ave St. 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) ....., 1884 (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Maid
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private family

9-BIRTHPLACE, (State or Country), Richmond Co. Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Marie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hester Hoggs

(Address) 12 Argyle Ave

15-

Filed DEC 11 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 7 1920, that I saw her alive on Dec 1920, and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Possibly Syph

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John E Stewart M. D.

1918, 191.. (Address) 916 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec 11, 1920

20-UNDERTAKER Samuel Ramsey — ADDRESS 1100 Eutaw

Fill out important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20. 44847 HEALTH DEPARTMENT—CITY OF BALTIMORE 20. 48847

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Bucking

(a) RESIDENCE. No. 38 1/2 Fernwood Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Frederick G. Bucking

6 DATE OF BIRTH (month, day, and year) March 14, 58

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Romefelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F. G. Bucking (Address) 1410 N. Montford Ave.

15 Filed DEC 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Dec. 10, 1920, that I last saw h— alive on Dec. 10, 1920, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 4.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucien L. Rodgers, M. D.

12/15, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Dec. 13 1920

20 UNDERTAKER William Cook ADDRESS 502 E. North Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48848 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48848

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 527 East 38th St.; 9 Ward)

2-FULL NAME Virginia F. Payne

(a) RESIDENCE. No. 527 East 38th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Payne

6 DATE OF BIRTH (month, day, and year) Dec 14-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudon Co Va

12 MAIDEN NAME OF MOTHER Lydia Hutchison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Samuel N. Payne

(Address) 318-14th St N.W. Wash D.C.

15 Filed DEC 11 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Dec 10, 1920, that I last saw her alive on Dec 10 20, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

Senility.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? — Physical findings

(Signed) J. H. Roberts, M. D.

, 19 (Address) 1451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL 12/11 1920

20 UNDERTAKER William Cook Co. ADDRESS 50 & Kenilworth

TION is very important. See instructions on back of certificates. EXAMPLE: If wife, state occupation of husband; if child, state occupation of father; if dependent, state occupation of person on whom dependent; if occupation has changed, state former occupation; if occupation may be properly classified, state kind of business in which employed.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48849

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Dolphin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Young

(Residence in Baltimore: No. 625 Dolphin St.: 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col.	Married

6-DATE OF BIRTH, Unknown (Month), (Day) 18[illegible] (Year)

7-AGE,	If LESS than 1 day,
28 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Moses Dixon

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice Douglass

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Young

(Address) 625 Dolphin St.

15-

Filed DEC 11 1920, 191

Robert F. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8 1920, to Dec 8 1920, that I saw her alive on Dec 8 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Heart disease, cardiac insufficiency

Probably only a month or two.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Chenoweth M. D.

Dec. 9, 1920. (Address) 2426 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Dec. 11, 1920

20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48850 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48850

CERTIFICATE OF DEATH

1-PLACE OF DEATH South Balto Gen. Hospital 151

CITY OF BALTIMORE: (No. 1213 Light ST.: 24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Graham

(a) RESIDENCE. NO. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 20

7 AGE — Years — Months — Days — If LESS than 1 day, 9 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Stanley F Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura L Canty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Stanley F Graham
(Address)

15 Filed DEC 11 1920 19

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-10 1920

17

I HEREBY CERTIFY, That I attended deceased from 12-10, 1920, to 12-10, 1920, that I last saw h alive on 12-10, 1920, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH was as follows*: Premature birth (7 months.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L Tolson M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: John F Deacon — ADDRESS: 715 Light St

TION is very important. See instructions on back of certificates.

20.48851 HEALTH DEPARTMENT--CITY OF BALTIMORE 20.48851

CERTIFICATE OF DEATH 10-041

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 262 E. Hamburg St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Dreibach.

(Residence in Baltimore: No. 262 E. Hamburg St. 29 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 MARRIED (or WIDOWED, or DIVORCED): Married

6 DATE OF BIRTH: Not Known (Month) (Day), 1 (Year)

7 AGE: 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: House Work (b) General nature of industry, business, or establishment in which employed (or employer): At Home 037

9 BIRTHPLACE (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Patrick Denna

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George A Dreibach

(Address) 262 E Hamburg St

15.

DEC 11 1920 Robert P. Harrison, 191 REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 8" (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1- 1920 to Dec 8 1920 that I saw h[illegible] alive on Dec 8" 1920 and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Duration) yrs. mos. 3 da

Contributory (SECONDARY) La Grippe (Duration) yrs. mos. 10 ds.

(Signed) Wm. B. McDonald M. D.

12/9 1920 (Address) 1323 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Dec 13 1920

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

...ATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ...is very important. See instructions on back of certificate.

D.48852

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.48852

CERTIFICATE OF DEATH

1920

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE (No. 1527 N. Fawn ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henrietta Priscilla Fletcher

(Residence in Baltimore: No. 1527 N Fawn St. S.: 79 yrs. 8 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

6 DATE OF BIRTH: March 24, 1841 (Month) (Day) (Year)

7 AGE: 79 yrs. 8 mos. 16 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Snow Hill, Md

PARENTS

10 NAME OF FATHER: John Taylor

11 BIRTHPLACE OF FATHER (State or country): Snow Hill, Md.

12 MAIDEN NAME OF MOTHER: Sophie McAllen.

13 BIRTHPLACE OF MOTHER (State or country): Snow Hill, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norma E. Fletcher

(Address) 1527 N. Fawn St

15 Filed DEC 11 1920, 191 Robert P. Harrison, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 9, 1920. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1920, to Dec. 9 1920, that I saw h[illegible] alive on DEC. 9 1920, and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

Not Known (Duration) — yrs. — mos. — ds

Contributory (SECONDARY) Indefinite

Not Known (Duration) — yrs. — mos. — ds.

(Signed) H. H. Arthur M. D.

DEC 9, 1920. (Address) 1426 N Fawn St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Dec 11 1920

20 UNDERTAKER: F. C. Shippert — ADDRESS: 2236 Eutaw

DO NOT WRITE IN THIS SPACE

Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 48853 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48853

CERTIFICATE OF DEATH.

912

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 611 S Bethel St.; 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Margaret Smith

(Residence in Baltimore: No. 611 S Bethel St.; ..... yrs., 8 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 2 (Day), 1920 (Year)

7-AGE, ... yrs. 8 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Ed. Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Long

(Address) 611 S. Bethel

15-

Filed DEC 1 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 8 1920, that I saw her alive on Dec 8 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. Wade M. D.

Dec 8, 1920 (Address) 11 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents — DATE OF BURIAL, Dec. 11, 1920

20-UNDERTAKER William Hollyoak Jr. — ADDRESS Eastern Ave.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48854 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48854

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1105 Maryland ST.: apt WARD)

2-FULL NAME Harry M. Wickes

(a) RESIDENCE. No. 1105 Maryland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian B. Wickes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Designer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Clothing Business

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edwardt Wickes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lillian B. Wickes

(Address) 1105 Maryland Ave

15 Filed DEC 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9" 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 9" 1920, that I last saw h[illegible] alive on Dec 9 1920, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Bronchitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gunaral Bronchitis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

12/13/1920 (Address) 1009 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/13 1920
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal ave

TION is very important. See instructions on back of certificates.

D.48855 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. St.: 21 + 183 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Champion.(C).

(Residence in Baltimore: No. 1004 S. Eutaw St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, September 9th, 1904, 1
(Month) (Day) (Year)

7-AGE, 16 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Portsmouth Va.

PARENTS.

10-NAME OF FATHER, Miles Wright.(C).

11-BIRTHPLACE OF FATHER (State or Country). Portsmouth Va.

12-MAIDEN NAME OF MOTHER Hattie Ferguson.(C).

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Everett.(C).(sister).

(Address) 416 N. Hamburg Street.

15-

Filed ....., 191.....

DEC 11 1920 Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8th, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

External and Internal Hemorrhage due to stab wound in the chest.
Homicide.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

(Signed) H. O. Feinhardt M.D.
(Coroner.)

Dec. 11th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....104 E. Hill Street.....

Former or usual residence Portsmouth Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Dec. 13 1920
20-UNDERTAKER John H. Loudin	ADDRESS 142 Druid Hill Ave

Important. See instructions on back of certificate. Cause of death must be properly classified. Exact statement of OCCUPATION is very

20,48856 HEALTH DEPARTMENT--CITY OF BALTIMORE 20,48856

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1321 N. Stricker St. 15 WARD) REGISTERED No. C 42

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Lindsey

(Residence in Baltimore: No. 1321 N. Stricker St. St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: C

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec 11, 1882 (Month) (Day) (Year)

7-AGE: 87 yrs. 11 mos. 29 ds. If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland.

PARENTS

10-NAME OF FATHER: Geo. A. Colbert.

11-BIRTHPLACE OF FATHER (State or country): Maryland.

12-MAIDEN NAME OF MOTHER: Ellen Dorsey

13-BIRTHPLACE OF MOTHER (State or country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melora Simms

(Address) 14 Cathedral St Annapolis

15- DEC 11 1920 Filed ..., 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1920, to Dec 10 1920, that I saw h[er] alive on Dec 9th, 1920, and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:

Primary cancer uterus - secondary growth, lungs, brain, glands, liver. (Duration) 1 yrs. ? mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed), Harry S. McCarty M. D.

Dec 10 1920 (Address) 31 W Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Annapolis Md — DATE OF BURIAL: Dec 12, 1920

20-UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTON ST

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48857 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 91

CITY OF BALTIMORE: (No. New City Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Abrams

(a) RESIDENCE. No. 1363 Carey St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed DEC 11 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 19 20

17 I HEREBY CERTIFY, That I attended deceased from December 2, 19 20, to December 8, 19 20, that I last saw h.im alive on December 7, , 19 20, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Gangrene of both legs + feet. (Frost-bite).
unknown.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy.

(Signed) F. C. Holden, M. D.
12/8/19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	DEC 12 19 20
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1503 PRESTMAN ST

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D.48858 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48858

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Berwick Av Hamilton (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Frederick

(a) RESIDENCE. No. Berwick Av ST., Hamilton WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph M. Frederick

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louanna Palzer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Joseph M. Frederick
(Address) Hamilton

15 Filed ..., 19... Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10. 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 21, to Dec 10, 19 21, that I last saw h-r alive on Dec 10, 19 21, and that death occurred, on the date stated above, at 6.20 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Toxaemia of Pregnancy (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clark Bruns, M. D.

(Address) 4706 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Hamilton	12/11 1921
20 UNDERTAKER Wm Cook	ADDRESS 5016 Nor

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

20.48859 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48859

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Ave ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita R. Ravels

(Residence in Baltimore: No. Union Ave Morrell Park St.; yrs., 4 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngl

6-DATE OF BIRTH, April (Month) 1 (Day), 1916 (Year)

7-AGE, yrs. 4 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Samuel Ravels

11-BIRTHPLACE OF FATHER (State or Country), Balto city

12-MAIDEN NAME OF MOTHER Mary Gauer

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Ravels

(Address) Union Ave

15- DEC 11 1920 Robert P. Harrison, Registrar.
Filed ....., 191.....
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Asphyxiation by Illuminating Gas. Shot Probably accident
At Same time Mother
Coroner Inquest (Duration) ..yrs..mos..ds.

CONTRIBUTORY (Secondary)
..... (Duration) ..yrs..mos..ds.

(Signed) James A. Faulkner M. D.
(Coroner.)
Dec 11, 1920 (Address) 700 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.

Where was disease contracted, if not at place of death? Union Ave

Former or usual residence Union Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincents	Dec 14, 1920
20-UNDERTAKER	ADDRESS
Williams Cook	502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48860 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48860

CERTIFICATE OF DEATH. 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Ave Morrell Park St.; 25 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ravis

(Residence in Baltimore: No. Union Ave Morrell Park St.; yrs., 4 mos..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... June (Month) 25 (Day), 1847 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. ..... mos. 16 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, James Greer

11-BIRTHPLACE OF FATHER (State or Country) Penna.

12-MAIDEN NAME OF MOTHER Ellen Hayes

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel L. Ravis

(Address) Union Ave - Morrell Pk

15- Robert P. Harrison,

Filed ..... 191.....

DEC 11 1920 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation from Illuminating Gas
Suicide

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Insanity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fulton M. D.
(Coroner.)

Dec 11, 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Union Ave

Former or usual residence Union Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincents	Dec. 14, 1920

20-UNDERTAKER	ADDRESS
William Cook	532 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.48861 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48861

CERTIFICATE OF DEATH.

REGISTERED No. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Sargeant ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jonathan E. Bradley

(Residence in Baltimore: No. 1140 Sargeant St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec (Month) 3 (Day), 1920 (Year)

7-AGE, ...yrs....mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John G. Bradley

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Folks

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Bradley

(Address) 1148 Sargeant St

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Dec 11 1920, that I saw her alive on Dec 11 1920, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Mal Formation of Heart

Lues of Heart Causing Pneumonia

one week (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs....mos....ds.

(Signed) Stephen D. Davis M. D.

Dec 11, 1920 (Address) 1229 Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Dec. 13, 1920
20-UNDERTAKER	ADDRESS
James Digrand & Son	1000 S. Paca St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48862 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48862

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N Gilmor ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie C Williams

(Residence in Baltimore: No. 8 years 212 N. Gilmor St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan (Month) 23 (Day), 1856 (Year)

7-AGE, 54 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, H Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Denton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert L. Williams

(Address) 212 N. Gilmor St.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Dec 6 1920, that I saw h[illegible] alive on Dec 6 1920, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows: Hardening Enlargement of Prostate

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

March 2, 191.. (Address) 1322 Hanl[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Dec. 11, 1920.

20-UNDERTAKER Harry D. Metzger

ADDRESS 1531 N Fremont Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

48863 D. 48863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 176

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Wilcox

(a) RESIDENCE. NO. Alma W. Va. ST., WARD. U. C. U.S.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Stephen C. Wilcox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary McCandlish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant (Address) Alberfield Wards

15 DEC 12 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25th, 1920, to Dec. 11th, 1920, that I last saw him alive on Dec. 11th, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy

Pyelo-nephritis

Cystitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia + pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Alma, W. Va.

Did an operation precede death? Yes. Date of Nov. 3rd, 20.

Was there an autopsy? Yes.

What test confirmed diagnosis? Cystoscopy + blood urea.

(Signed) H. Hatley, M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alma W. Va. DATE OF BURIAL: Dec 11 192.

20 UNDERTAKER: John D. Mitchell ADDRESS: 201 W. Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48864 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48864

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3212 Fleet ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise J. Byard

(a) RESIDENCE. No. 3212 Fleet ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Byard

6 DATE OF BIRTH (month, day, and year) Jan 21, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Byard

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm L Byard
(Address) 3212 Fleet St

15 Filed DEC 12 1920 ROBERT F. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1920, to Dec 9, 1920, that I last saw h.. alive on Dec 9, 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Thyrocarditis

(duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

Rheumatism (duration) 40 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ned Kaminsky M. D.

12/10, 1920 (Address) 3035 E Dowell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	12-13 1920
20 UNDERTAKER	ADDRESS
Stephen F Fiackowaks	100 Spruce

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048865 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048865

CERTIFICATE OF DEATH. 110

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Stone

(a) RESIDENCE. NO. 803 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joe Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy – Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address) J. H. H.

15 Filed DEC 12 1920 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 10th 1920, that I last saw h[illegible] alive on Dec 10-th 1920, and that death occurred, on the date stated above, at 5.25 p.m.

The CAUSE OF DEATH* was as follows:

Proctitis & Perproctitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Don't Know

Did an operation precede death? No (Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. R. Mason M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	Dec 12 1920
20 UNDERTAKER Daniel Easton	ADDRESS 916 E. Balt

TION is very important. See instructions on back of

Spec.~~6-9-19~~—H. P. Co.—1000 Bks.

D48866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48866

CERTIFICATE OF DEATH.

8-09

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1410 Ward ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Filoretta Diggs

(a) RESIDENCE. No. 1410 Ward ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Diggs

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Rose Allen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Rose Diggs
(Address) 1410 Ward

15 Filed DEC 12 1920 ROBERT B KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 10, 1920, that I last saw h[illegible] alive on Dec 9, 1920, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough ?

(duration) yrs. mos.) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

12/11/20 (Address) 29 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 12 20
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Ga Ave

TION is very important. See instructions on back of certificates.

D48867 HEALTH DEPARTMENT—CITY OF BALTIMORE D48867

CERTIFICATE OF DEATH. 8-09

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1206 Rutter St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anatis Washington

(Residence in Baltimore: No. 1206 Rutter St. St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 18, 1920 (Month) (Day) (Year)

7-AGE. yrs. 4 mos. 22 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: nurse
(b) General nature of industry, business, or establishment in which employed (or employer): (infant)

9-BIRTHPLACE, (State or Country), Rock Hall, Md.

PARENTS.

10-NAME OF FATHER, Anatis Washington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Carrie Thompson

13-BIRTHPLACE OF MOTHER (State or Country). Rock Hall, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. N. Washington

(Address) 1206 Rutter St.

15- Filed DEC 12 1920, 191.... ROBERT B ERAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Whooping cough.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) J. R. Hennessy M. D. (Coroner.)

Dec'd, 1920 (Address) 2802 Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

*18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 12, 1920

20-UNDERTAKER Daniel Easton — ADDRESS 916 Pe ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L948868 HEALTH DEPARTMENT—CITY OF BALTIMORE L948868

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N High ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Forman

(a) RESIDENCE. No. 210 N High ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., If of foreign birth? 33 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Forman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Lillie Forman (Address) 215 N High St

15 Filed DEC 12 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17 I HEREBY CERTIFY, That I attended deceased from on Dec. 8, 1920, to —, 19..., that I last saw him alive on Dec. 8, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver - Jaundiced

about

(duration) Del yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? J H Hollenberg

(Signed) ..... M. D.

Dec 11th, 1920 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henry Park	Dec 12 1920
20 UNDERTAKER Max Levinson	ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48869 HEALTH DEPARTMENT—CITY OF BALTIMORE D48869

CERTIFICATE OF DEATH.

REGISTERED NO. C 115

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Miller

(Residence in Baltimore: No. 2416 E Balto st St.; 40 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November, 18, 76
(Month) (Day) (Year)

7-AGE, 50 yrs. ~ mos. ~ ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butter Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Ok

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Mr Kroun

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mr Kroun

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S Miller
(Address) 2416 E Balto. st

15-DEC 12 1920 ROBERT B KRAUTER
Filed....., 191.... Registrar.
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28, 1920, to Dec 10 1920, that I saw h alive on Dec 10 1920, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
Acute Cardiac Dilatation
Malacystitis
(Duration) ....yrs. ....mos. 3 ds.
CONTRIBUTORY (Secondary) Thrombo Angiitis Obliterans
(Duration) 4 yrs. 8 mos. 7 ds.
(Signed) Louis Jacobs M. D.
Dec 10, 1920 (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence 2416 E Balto. st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale
DATE OF BURIAL, Dec 12, 1920

20-UNDERTAKER Max Levinson
ADDRESS 1127 E Balto. st.

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-24-14—M. & T.—2000 Bks.

D48870 HEALTH DEPARTMENT—CITY OF BALTIMORE D48870

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 E. Fayette St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Levin

(Residence in Baltimore: No. 1432 E. Fayette St.; ..... yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Sing'l

6-DATE OF BIRTH, Oct. 26, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 1 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Adolph Levin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Yetta Sachs

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin

(Address) 1411 E. Balto St.

15-

Filed DEC 12 1920, 191.....

ROBERT B. KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1920, to Dec. 10, 1920, that I saw h er alive on Dec. 9, 1920, and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Lesion

Patent Foramen Ovale (Congenital)

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Isaac M. Marks M. D.

Dec. 11, 1920 (Address) 7357 Cutler Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mash Rd

DATE OF BURIAL, 12-12, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

Spec.—8-24-14—M. & T.—2000 Bks.

D48871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48871

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2001 E Baltx

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Hebrew aged Home St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Sarah Feinstein also known as Jennie Fan Lichterman

(Residence in Baltimore: No. 117 N. Exeter St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 78 — — ....yrs....mos....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balt St

15- Filed DEC 12 1920, 191... ROBERT E LEACH Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 11th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4th 1920, to Dec. 10 1920, that I saw h[er] alive on Dec 10 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hemoplegia, Myocarditis

(Duration).....yrs.....mos.....ds.

(Signed) W J Baugh M. D.

12/11/20, 191... (Address) 210 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State 15 yrs. mos. ds.

Where was disease contracted, if not at place of death? 117 N Exeter St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 12/13, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48872

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D48872

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 W Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Lewis

(Residence in Baltimore: No. 144 W. Hamburg St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Not known, 1 .....
(Month) (Day) (Year)

7-AGE, About
46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Maiden North Carolina

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country). Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Floyd

(Address) 144 W. Hamburg St.

15 DEC 12 1920 ROBERT P. KRAUTER

Filed ....., 191.... Burial permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 5 1920, to Dec. 9 1920, that I saw h[illegible] alive on Dec. 9 1920, and that death occurred, on the date stated above, at 7.04 m.

The CAUSE OF DEATH* was as follows:

.....Apoplexy.....

..... (Duration) .....yrs. .....mos. 5 ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) D. L. Shelton M. D.

Dec. 10, 1920 (Address) 324 W. Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Gastonia N. C. DATE OF BURIAL, Dec. 12, 1920

20-UNDERTAKER R. L. Parham ADDRESS 649 W. Lee St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L048873 **HEALTH DEPARTMENT—CITY OF BALTIMORE** L048873

CERTIFICATE OF DEATH. -37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Unavanitch (Urbanavic)

(a) RESIDENCE. No. Westport (Veale Station) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hosp Records

(Address)

15 Filed DEC 12 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to Dec 11, 1920, that I last saw him alive on Dec. 10, 1920, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & serological test

(Signed) B. C. Medairy M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 14 1920
20 UNDERTAKER	ADDRESS
John Grabliauckas	425 S. Pac

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48874 HEALTH DEPARTMENT—CITY OF BALTIMORE D48874

CERTIFICATE OF DEATH. +45

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Gregg Pernet

(a) RESIDENCE. NO. 50 Central Park W. N.Y. City ST., WARD. New York City.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John M. Pernet

6 DATE OF BIRTH (month, day, and year) June 6th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Texas
(State or country)

PARENTS

10 NAME OF FATHER Endymion B. Gregg.

11 BIRTHPLACE OF FATHER (city or town) Tennessee
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Williams

13 BIRTHPLACE OF MOTHER (city or town) Mississippi
(State or country)

14 Informant Virginia P. Lawrence
(Address) New York

15 Filed DEC 12 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from December 6, 1920, to December 11th, 1920, that I last saw her alive on December 11th, 1920, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Dec 9th 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) Jno. Finney Jr. M. D.

Dec 11, 1920 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nashville Tenn	19

20 UNDERTAKER Henry H. Jenkins Son Co ADDRESS Nashville Tenn

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48875 HEALTH DEPARTMENT—CITY OF BALTIMORE D48875

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Leo Spalz

(Residence in Baltimore: No. Aisquith St & Ashland Ave St.; 2 yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... June (Month) ..... 17 (Day), 1842 (Year)

7-AGE,	If LESS than 1 day,
78 yrs. 5 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... Convent

9-BIRTHPLACE, (State or Country), Aschaffenburg Germany

PARENTS.

10-NAME OF FATHER, Michael Spalz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Kuhlmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionysia

(Address) Notre Dame Convent Aisquith St

15- Filed DEC 12 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) ..... 9 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1920, to Dec 9 1920, that I saw her alive on Dec. 9 1920, and that death occurred, on the date stated above, at 11.15 p. m.

The CAUSE OF DEATH* was as follows:

..... Broncho pneumonia

.....

..... (Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

Dec 10, 191.. (Address) 1113 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md	Dec 13, 191..
20-UNDERTAKER	**ADDRESS**
Frank A Fink	915 N Gay

1048876 HEALTH DEPARTMENT---CITY OF BALTIMORE 1048876

CERTIFICATE OF DEATH

64

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No 1244 E. North Ave. St.: 9th. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur L. Thompson

(Residence in Baltimore: No. 1244 E. North Ave. St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: Nov (Month) 29 (Day) 1853 (Year)

7-AGE: 67 yrs. – mos. 10 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Health Dept

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Arthur D. Thompson

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Alice J. Eley

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella V. Thompson

(Address) 1244 E. North Ave

15 Filed DEC 12 1920 191 — ROBERT B KRAUTER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December (Month) 10. (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1920, to December 10. 1920, that I saw h[illegible] alive on December 10. 1920, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-sclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Cerebral Apoplexy

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) George A. Hartman M. D.

Dec. 12, 1920 [Address] 2214 Mayfield Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: DEC 13 1920

20-UNDERTAKER: John A. Mitchell — ADDRESS: 1201 W. Fayette St

TION is very important. See instructions on back of certificate.

D48877 HEALTH DEPARTMENT--CITY OF BALTIMORE D48877

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 79

CITY OF BALTIMORE (No. 1009 Madison Ave St. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Marshall Smith

(Residence in Baltimore: No. 1009 Madison Ave St.; 58 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	White	Married

6 DATE OF BIRTH May 26, 1862 (Month) (Day) (Year)

7 AGE 58 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) 055

9 BIRTHPLACE (State or country) Va

PARENTS

10 NAME OF FATHER Bennett W. Smith

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Matilda Janey

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennette W. Smith

(Address) 1009 Madison Ave

15 DEC 12 1920 Filed ..... 191 ROBERT F. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 11, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1915, to Dec 10 1920

that I saw h[illegible] alive on Dec 10, 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Fibrosis

and Acute Dilatation

(Duration) yrs. 5 mos. ds

Contributory (SECONDARY) Fem Lues,

(Duration) yrs. mos. ds.

(Signed) Stewart McLeary M. D.

....., 191 (Address) E 1609 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Dec 13, 1920

20 UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48878 HEALTH DEPARTMENT—CITY OF BALTIMORE D48878

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 836 N. Gay St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas George Scharnagl.

(a) RESIDENCE. No. 836 N Gay ST., ... WARD. (Resident)

(Usual place of abode) abnt

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 50 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Virginia Scharnagl

6 DATE OF BIRTH (month, day, and year) May-15-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Picture Frames &c.

(c) Name of employer (Self.)

9 BIRTHPLACE (city or town) (State or country) not known Germany

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Germany

14 Informant Mrs Laura V. Scharnagl (wife) (Address) 836 N Gay St.

15 Filed DEC 12 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1920, to Dec 10th, 1920; that I last saw him alive on Dec 10th, 1920; and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pericarditis 8

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arthritis 4

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

19 (Address) 1-07 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Dec 13 1920.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

D48879 HEALTH DEPARTMENT—CITY OF BALTIMORE D48879

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pershing Godwin

(Residence in Baltimore: No. 125 Prospect Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August (Month) 15 (Day), 1918 (Year)

7-AGE, 2 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William F. Godwin

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth R.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. F. Godwin (Father)

(Address) 125 Prospect Ave

15- DEC 12 1920 ROBERT B KRAUTER

Filed....., 191.... REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bursos 1st & 2nd Degree - Accidental - Flame inhalation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Dec 10, 1920 (Address) 1639 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. few minutes ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

125 Prospect Ave - Balti. Md

Former or usual residence 125 Prospect Ave.

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Dec 13, 1920

20-UNDERTAKER STEVENSON-BROWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

BURIAL PERMIT ISSUED

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048880 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048880

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 708 So. Regester ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JADWIGA BARTKOWIAK,

(a) RESIDENCE. NO. 1006 So. Harris Ally ST., I- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Bartkowiak,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife, 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Wojciech Kalisak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Grusczynska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mary Krysiak (Sister)

(Address) 708 So. Regester Street

15 Filed DEC 12 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 19 20, to Dec 10, 19 20, that I last saw h alive on Dec 10, 19 20, and that death occurred, on the date stated above, at 9.00 P- m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wenclas M. D.

19 (Address) 708 So. Regester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery,	Dec-13- 19 20
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048881 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048881

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Barclay St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah D Bevens

(a) RESIDENCE. No. 3210 Barclay St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1878

7 AGE 42 Years 10 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandy Spring Md

PARENTS

10 NAME OF FATHER Peter Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sempsie Ankrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha E. Hammond
(Address) 3210 Barclay St

15 Filed DEC 12 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1920, to Dec 10th, 1920, that I last saw her alive on Dec 10th, 1920, and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia and pleurisy

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) pneumonic infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No 3210 Barclay St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Ted L. Hall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cmty	Dec 12 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Ensor

Holland

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bredehoeft

1048882

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048882

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md. General Hosp ST. 27 WARD)

2-FULL NAME Rowland J. Bredehoeft

(a) RESIDENCE. No. 104 Hamilton Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Canton Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Bredehoeft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lilly Masterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lilly Bredehoeft

(Address) 104 Hamilton Ave

15 Filed DEC 12 1920 ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1920

17

I HEREBY CERTIFY, That I attended deceased from October 28, 1920, to Dec 9, 1920, that I last saw h/ alive on Dec 9, 1920 and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Empyema - OVER
osteomyelitis of rib Rt. Chest.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardio Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? Yes Date of Sept 13, 20

Was there an autopsy? No

What test confirmed diagnosis? Operation + Xray

(Signed) W. F. Finney Frumpkin, M. D.

19 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Dec 13 1920
20 UNDERTAKER	ADDRESS
Hy & Wes John W. Teufel	501 W. Fayette

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient had TB at Endowood: Case reported to Tuberculosis Division. Arrested case then developed empyema. See chart in Nursing division.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48883

CERTIFICATE OF DEATH.

92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 500 N Bruce St ST.: 16 WARD)

2-FULL NAME Chas Dahl

(a) RESIDENCE. NO. 500 N Bruce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Warden

(b) General nature of industry, business, or establishment in which employed (or employer) City Jail

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Dahl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dutt Kuer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dust Kuer

14 Informant Mrs. Annie Dahl

(Address) 500 Bruce St.

15 Filed DEC 12 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/20 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 6/20, 19..., to Dec 10/20, 19...,

that I last saw h[illegible] alive on Dec 9/20, 19...,

and that death occurred, on the date stated above, at 3 am .m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

Nephritis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Doucet M.D., M. D.

, 19 (Address) 19 S Gilmor St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Dec 13 1920

20 UNDERTAKER Williams Cook

ADDRESS 502 E Baltimore

THIS is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1948884 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948884

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 Whittier Ave St.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isidor Sulzbacher

(Residence in Baltimore: No. 2301 Whittier Ave St.; Lifetime (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 18th (Day), 1867 (Year).

7-AGE, 53 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painting
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salesman

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Isaac Sulzbacher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emelie Marsalsky

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs I Sulzbacher

(Address)..... 2307 Whittier Ave

15-

Filed DEC 12 1920 ROBERT E KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Dec 10 1920, that I saw h.... alive on Dec 10 1920, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Benj. F. Phillips M. D.

Dec. 11, 1920 (Address) 1929 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Har Sinai — DATE OF BURIAL, Dec. 12, 1920.

20-UNDERTAKER Ward & Goodman — ADDRESS 1[illegible]

1048885 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048885

CERTIFICATE OF DEATH.

64

PLACE OF DEATH

CITY OF BALTIMORE (No. Marlborough Aprt., ST.: 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospitnt or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel F.Brown,

(Residence in Baltimore: No. Marlborough Aprt. Eutaw Place & Wulsons St.; 16. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Feby. (Month) 20th. (Day), 1858. (Year)

7-AGE, 62 yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Vinéger Mnfg.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Cincinnatti Ohio,

PARENTS.

10-NAME OF FATHER, Ferdinand Brown,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Sophia Klopfer,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L.Bear,

(Address) Marlborough,Aprt.

15- DEC 12 1920 ROBERT B KRAUTER

Filed ....., 191... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 11th. (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [redacted] (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
5 months (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 11, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto.Hebrew ,	Dec. 13..., 1920
20-UNDERTAKER	ADDRESS
D. and Sondheim	Howard & Lexington

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D48886 HEALTH DEPARTMENT—CITY OF BALTIMORE D48886

CERTIFICATE OF DEATH.

81

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 E Chase St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget McGinnity

(Residence in Baltimore: No. 817 E Chase St. St.; 5 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, not known, ... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 87 3 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Helen McGinnity

(Address) 817 E Chase St.

15- Filed DEC 12 1920 ROBERT B KRAUTER REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 1920, to Dec 10 1920, that I saw her alive on December 10 1920, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

.....

Arteriosclerosis

..... (Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) 2 yrs. 7 mos. ds.

(Signed) William L Ford M. D.

12-11, 1920 (Address) Westminster

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, 12/13/..., 1920

20-UNDERTAKER J. G. Moran

ADDRESS 2000 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48887 HEALTH DEPARTMENT—CITY OF BALTIMORE D48887

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Henry Myers.

(a) RESIDENCE. (No.) 7 Green's Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. D40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Wm. Mackin & Co. 1762 Fremont ave

15 DEC 13 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 12 1920

17 I HEREBY CERTIFY, That I attended deceased from November 23, 1920, to December 12, 1920, that I last saw him alive on December 11, 1920, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Myocardis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) C. Wilbur Stuart, M. D.

12/12, 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 14 1920
20 UNDERTAKER	ADDRESS
Henry Horch & Son	1301 E Eager

How is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D48888 HEALTH DEPARTMENT—CITY OF BALTIMORE D48888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Riggs Ave. St.; 16 WARD) 1-092 REGISTERED No. C.....

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Marion B. Harrison

(Residence in Baltimore: No. 2210 Riggs Ave St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, April (Month) 1 (Day), 1883 (Year)

7-AGE, 37 yrs. 8 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of Industry, business, or establishment in which employed (or employer) Home 037

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Oliver H Birney

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Henrietta Chapman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse D. Harrison

(Address) 2210 Riggs Ave

15- DEC 13 1920 ROBERT I. KRAUTER

Filed....., 191..... Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1920, to Dec 9 1920, that I saw h alive on Dec 9 1920, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Charles E. Clarke M. D.

Dec 13, 1920 (Address) 1306 Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Dec 13, 191..

20-UNDERTAKER Josiah Depue & Son ADDRESS W North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048889 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048889

CERTIFICATE OF DEATH. STILLBIRTH No. 152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Moody

(a) RESIDENCE. No. Hebrew Hospital ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work depart ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas F. Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richford, Va.

12 MAIDEN NAME OF MOTHER Tillian M. Mannix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Md.

14 Informant Mrs. Tillian M. Moody
(Address) Hebrew Hospital

15 DEC 13 1920 ROBERT F KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Dec. 10, 1920, that I last saw him alive on Dec. 10, 1920, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia pallida

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. R. Koontz, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johns Hopkin Laboratory	19
20 UNDERTAKER A. R. Koontz.	ADDRESS

This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48890

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 S 13th St. Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Thomas

(a) RESIDENCE. No. 331-13th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? — yrs. 1 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22nd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Catherine Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Miss Catherine Thomas

(Address) 331 S 13th St

15 DEC 13 1920 ROBERT E. LEAUTER Registrar

Burial or removal Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12th 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 22nd, 1920, to December 12, 1920, that I last saw h[illegible] alive on Dec 11th, 1920, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 470 n Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st German Cem	Dec 13 19[illegible]
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2044 Eastern

See instructions on back of certificates. Every question must be answered. Write plainly with pen and ink. Use no abbreviations. If unknown, say so. Do not leave blanks except when directed to do so. Be sure to answer every question. Please read carefully the instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48891

CERTIFICATE OF DEATH.

136

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE; (No. Hebrew Hospital St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Despeaux

(Residence in Baltimore: No. 2012 Bank St.; 17 yrs., 3 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Single

6-DATE OF BIRTH, September 3, 1903 (Month) (Day) (Year)

7-AGE. 17 yrs. 3 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Operator (Wool Burler)
(b) General nature of industry, business, or establishment in which employed (or employer) 686

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Adam Despeaux

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Laura Noff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Adam Despeaux

(Address) 2012 Bank St.

15- ROBERT F KRAUTER

Filed DEC 13 1920, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 11, 1920, that I saw her alive on Dec 11, 1920, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Eclampsia
(Cesarean Section)

(Duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jacob P. Greenberg M. D.

Dec 11, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ist German Cem. DATE OF BURIAL, Dec 14, 1920.

20-UNDERTAKER Peter Nicolaus ADDRESS 2044 Eastern Av

D48892

HEALTH DEPARTMENT--CITY OF BALTIMORE

D48892

CERTIFICATE OF DEATH

151

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 773 W. Saratoga ST.: 4 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Minor

(Residence in Baltimore: No. 773 W. Saratoga St.; yrs. 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: B

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ~~Not~~ Sept. 28, 1920 (Month) (Day) (Year)

7-AGE: ~~0~~ yrs. 2 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Baby 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Albert Watson

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Elsie Minor

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie Minor

(Address) 773 W. Saratoga St

15- DEC 13 1920 Filed ....., 191.....

ROBERT P. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 12, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to Dec 12 1920, that I saw h[er] alive on Dec 9, 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition - Inability to digest nourishment.

(Duration) ..... yrs. 1 mos. ..... ds

Contributory (SECONDARY) Tetany

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed), Gustav [illegible] M. D.

Dec 12, 1920 (Address) 1710 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Zion cemetery

DATE OF BURIAL: Dec 13, 1920

20-UNDERTAKER: Mrs Robt a elliott

ADDRESS 1725 Edmondson

IMPORTANT—DEATH must be REPORTED EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Bernard S Huff.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48893 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D48893

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No Municipal tuberculosis 27 ~~Hospital~~ St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Huff.

(a) RESIDENCE. No. 1017 Belvedere Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Anna Huff.

6 DATE OF BIRTH (month, day, and year) May 13 - 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER George Huff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Jennie Finch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Maryland.

14 Informant Clarence Huff

(Address) 1017 Belvedere Av Arlington

15 Filed DEC 13 1920 ROBERT B KRAUSER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Dec. 12, 1920, that I last saw h... alive on Dec. 12, 1920, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Cutable sarcoma upper third of right leg.

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary) Metastases to lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Argey. M. D.

. 19 (Address) Municipal Tb. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Silver Run. Carroll Co Md

DATE OF BURIAL 12/15/20

20 UNDERTAKER William Cook

ADDRESS Sore North

Spec.—8-9-19—H. P. Co.—1000 Bks.

D48894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48894

1-PLACE OF DEATH

REGISTERED NO. 47

CITY OF BALTIMORE: (NO. 1637 Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Palmeri

(a) RESIDENCE. NO. 1637 Jefferson st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May-4-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincenzo Palmeri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Santa Didomenico

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincenzo Palmeri
(Address) 1637 Jefferson st

15 Filed DEC 13 1920 ROBERT P. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Dec 11, 1920, that I last saw h. 27 alive on Dec 11, 1920, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis Rheumatic
Pericarditis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Physical Signs

(Signed) Joseph Greskovich, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 12/13/20

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hoffman

THIS IS VERY important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48895 HEALTH DEPARTMENT—CITY OF BALTIMORE D48895

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Joseph's Hospital ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Martin

(a) RESIDENCE. No. 1941 N Collington Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44	44	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Furnace

PARENTS

10 NAME OF FATHER Coatsman Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William Martin

(Address) 1941 Collington Ave

15 Filed DEC 13 1920 ROBERT T. NEWCOMB Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Dec. 17, 1920 that I last saw him alive on Dec. 10, 1920 and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intra Ventricular Hemorrhage

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S Cheverick, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Francis Country Aberdeen	Dec 15 1920
20 UNDERTAKER	ADDRESS
Howard K McKenna	Aberdeen

TION is very important. See instructions on back of certificates. Exact statement of death

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48896

CERTIFICATE OF DEATH.

5-79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No: 1021 E. Fayette ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bowers

(a) RESIDENCE. No. 1021 E. Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bowers

6 DATE OF BIRTH (month, day, and year) Nov., 14th. 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 088

(b) General nature of industry, business, or establishment in which employed (or employer) Harness Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jasper Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas. H. Brune

(Address) 1021 E. Fayette St.

15 Filed DEC 13 1920 ROBERT A. BRAUNE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec., 11th. 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1920, to Dec. 10, 1920, that I last saw him alive on Dec. 10, 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Green, M. D.

12-11, 1920 (Address) 120½ Leisguith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 13th 1920
20 UNDERTAKER	ADDRESS
C.F.Evans & Son	116 W. Mt.Royal Ave

Read carefully important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D48897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3611 Old York Road ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Anne Dean

(Residence in Baltimore: No. 3611 old York Road St.: 80 yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) widow

6-DATE OF BIRTH, Sept (Month) 20 (Day), 1840 (Year)

7-AGE, 80 yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Gorsuch

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Caroline A. Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Baynard

(Address) 3611 Old York Road

15-

DEC 13 1920

Filed ....., 191.... ROBERT B KRAUTZ Deputy Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11th 1920, to Dec 11 1920, that I saw her alive on Dec 11 1920, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Paralysis accompanied by Bright's Disease & Heart complications

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

....., (Duration) ....yrs. ....mos. ....ds.

(Signed) E. H. Dunean M. D.

Dec 13, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk

DATE OF BURIAL, Dec 14, 1920

20-UNDERTAKER Philip Herring

ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D48898

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3827 Fait Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Rodney.

(a) RESIDENCE. No. 3827 Fait Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 10 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11- 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buffer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Copper

(c) Name of employer Balto. Copper + Smelting Co,

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George W. Rodney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ellen Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Harry D. Rodney.
(Address) 3827 Fait ave

15 Filed DEC 13 1920 ROBERT B. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 1920, to Dec. 11th, 1920, that I last saw him alive on December 11th, 1920, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examin.

(Signed) D W. Jones, M. D.

12/13/ 19 20 (Address) 1013 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem.	Dec 15 1920
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1789 E. Eager

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 48899 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Phipps Clinic, Johns Hopkins Hospital 60 REGISTERED NO. C .....

CITY OF BALTIMORE: (No. ..... ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Smith Hartman

(Residence in Baltimore: No. 3418 Norwood Ave St.; 9 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	married

6-DATE OF BIRTH. April 14, 1870. (Month) (Day) (Year)

7-AGE. 50 yrs. 7 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: merchant 04
(b) General nature of industry, business, or establishment in which employed (or employer): Luggage mfrs

9-BIRTHPLACE. (State or Country). Pa. (Glenrock)

PARENTS.

10-NAME OF FATHER. John W. Hartman

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie B. Hohman

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.... ROBERT B KRAUTER Registrar.

Burial ... Dec 14

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1920, to Dec 11 1920, that I saw him alive on Dec. 11 1920, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

..... (Duration) ..... yrs. 1 mos. 8 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leslie B. Hohman M. D.

Dec. 11, 1920. (Address) Johns Hop. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 3 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec 14, 1920
20-UNDERTAKER	ADDRESS
F M Gaulbert	1624 Mc Cul. ave

D 48900 HEALTH DEPARTMENT--CITY OF BALTIMORE D 48900

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 263 E. Hamburg ST. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Dreisbach

(Residence in Baltimore: No. 263 E. Hamburg St. 78 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Widowed

6-DATE OF BIRTH: ——— (Month) ——— (Day), 1 (Year)

7-AGE: 78 yrs. — mos. — ds. If LESS than 1 day, — hr. — or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cooper
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Pennsylvania

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jos. R Wheeler

(Address) 263 E Hamburg St

15 DEC 13 1920 (Date), 191

ROBERT E KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3d 1920 to Dec 10, 1920
that I saw h[im] alive on Dec 9th p.m. 1920
and that death occurred, on the date stated above, at — m.
The CAUSE OF DEATH* was as follows:

Valvular heart disease
(Primary or Int.)
Probably Senile
(Duration) — yrs. — mos. — ds.
Contributory (SECONDARY) Rheumatism 12 yrs. at intervals
(Duration) — yrs. — mos. — ds.

(Signed) Wm. Blue McDonald M. D.
12/11, 191 20 (Address) 1323 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: LOUDON PARK — DATE OF BURIAL: DEC 13 1920

20-UNDERTAKER: JOHN F. DENNY — ADDRESS: 715 LIGHT ST.

If CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Theodora Wontropski.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2796 W. North Ave ST. 15 WARD) 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodora Wontropski

(a) RESIDENCE. No. 2796 W North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. - mos. - ds. How long in U. S., if of foreign birth? 34 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casimir Wontropski.

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Chas C. Wontropski. (Address) 1808 Eastern ave.

15 Filed DEC 13 1920 ROBERT J. KRAUTER Registrar

Burial Permit Olert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1920

17 I HEREBY CERTIFY, That I attended deceased from 11-6, 1920, to Dec 11, 1920, that I last saw h[illegible] alive on Dec 11, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach
Nephritis & Arterial Degeneration
Hypertension (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Lab's, Findings

(Signed) M. Kubinski, M. D.

12-13 1920 (Address) 800 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 16. 1920
20 UNDERTAKER	ADDRESS
M. Ludowske.	705 S. Ann

FOR IS VERY important. See instructions on back of certificates.

D 48902 Dubiel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 607 S Durham St. 3 WARD) REGISTERED No. C 91

2-FULL NAME Teresa Dubiel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 607 S Durham St St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 13, 1920
(Month) (Day) (Year)

7-AGE, 8 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). P.O.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Dubiel

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Eva Stadzycka

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Dubiel

(Address) 607 S Durham St

15- Filed DEC 13 1920 191 ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry L. Preston (Coroner) M. D.

12/13 1920 (Address) Fort Worth Tex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cem. DATE OF BURIAL, Dec 15, 1920

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Arch St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 48903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 569 Forrestman ST.: 14 WARD) 12

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pullman

(a) RESIDENCE. NO. 569 Forrestman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Emma Pullman

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of Industry, business, or establishment in which employed (or employer) Wholesale Coffee

(c) Name of employer Levering.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo. Pullman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Pullman

(Address) 571 Forrestman

15 Filed DEC 31 1920 19

ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 28 1920,

that I last saw him alive on Dec 27 1920,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McCard, M. D.

12/31, 1920 (Address) 2005 Druid Hillave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr D Auburn Cmty	Jan 1 1920

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

THIS is very important. See instructions on back of certificates.

D48904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48904

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1925 W Franklin St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel B. Fluckey

(Residence in Baltimore: No. 1925 W Franklin St.; yrs. 59. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov (Month) 4 (Day), 1861 (Year)

7-AGE, 59 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Police Sergeant
(b) General nature of industry, business, or establishment in which employed (or employer): City 061

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, John B Fluckey

11-BIRTHPLACE OF FATHER (State or Country) Nova Scotia

12-MAIDEN NAME OF MOTHER Margaret McCloskey ~~Scotia~~

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fluckey

(Address) 1925 W Franklin St

15- Filed DEC 13 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) yrs. suddenly mos. ds.

(Signed) James H Fenton M. D. (Coroner.)

Dec 11, 1920. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

1925 W Franklin St

Former or usual residence 1925 W Franklin St

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, 12-14, 1920

20-UNDERTAKER H C Brauning & Son — ADDRESS 317 N Schroeder St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1009 Bks.

D48905 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D48905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 N Carey St.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Swartzer

(a) RESIDENCE. No. 617 N Carey ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Moulder
(b) General nature of industry, business, or establishment in which employed (or employer): 047
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Swartzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ann Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Howard Swartzer
(Address) 617 N Carey St

15 Filed DEC 13 1920 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1920, to Dec 11, 1920, that I last saw him alive on Dec 11, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (duration) ..... yrs. ..... mos. 35 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical diagnosis

(Signed) E. Miller Hunning M. D.

12/14 1920 (Address) 2011 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 12-15 1920

20 UNDERTAKER: H. C. B. Hammond & Son

ADDRESS 617 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D48906

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

39 D48906

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 910 Edmondson Ave. WARD) 16

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas M. Robinson

(Residence in Baltimore: No. 910 Edmondson St.; 47 yrs. 1 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct (Month) 17 (Day), 1873 (Year)

7-AGE: 47 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Andrew Robinson

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Isabella Smith

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Offutt

(Address) 611 S Appleton

15. Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 13 1920

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 12 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Dec 12 1920, that I saw him alive on Dec 12, 1920 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cancer left jaw & tongue

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Cachexia

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Thos A Johnston M. D.

Dec 13, 1920 (Address) 1183 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL ~~OR REMOVAL~~: London Park — DATE OF BURIAL: Dec 14, 1920

20-UNDERTAKER: Geo W Little — ADDRESS: 531 N Fremont Ave

that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 48907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48907

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Ryan

(Residence in Baltimore: No. 404 N Stricker St.: 77 yrs. 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, August 20, 1848
(Month) (Day) (Year)

7-AGE, 77 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pottery Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry C. Ryan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elanor Pease

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Woolfe

(Address) 404 N Stricker St

15- DEC 13 1920 Robert P. Harrison, Registrar.
(Date) ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920, to Dec 12 1920, that I saw h[e] alive on Dec 12 1920, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Arrest Nephritis

(Duration) ....yrs. ....mos. 22 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) August Hom M. D.

....., 1920 (Address) 410 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Baltimore — DATE OF BURIAL, Dec 15, 1920

20-UNDERTAKER Geo W Little — ADDRESS 631 N Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

L048908 HEALTH DEPARTMENT---CITY OF BALTIMORE L048908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1291

CITY OF BALTIMORE: (No. 2721 Guilford Avenue ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel J. Ellinger

(a) RESIDENCE. No. 2721 Guilford Avenue ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace Myers

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Ellinger

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Pollard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant Mrs. Grace Ellinger
(Address) 2721 Guilford Avenue

15 Filed DEC 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1920, to Dec 12th, 1920, that I last saw h.. alive on Dec 12th, 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests

(Signed) J. H. Francis Brack, M. D.

Dec 17, 1920 (Address) 2840 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12/14 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

FOR IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.48909 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1457 Stevenson St. (Ward) 24

REGISTERED No. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Fischer

(a) RESIDENCE. No. 1457 Stevenson St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida C. Caldwell

6 DATE OF BIRTH (month, day, and year) Dont Know 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shipbuilder

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ernst Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida Fischer (Address) 1457 Stevenson St.

15 Filed Dec 13 1920 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6 1920, to Dec 11 1920, that I last saw h[e] alive on Dec 11 1920, and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart — over

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Neil Smith, M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edgewood Cem	12/13 1920
20 UNDERTAKER	ADDRESS
John J. Daly & Sons	318 Eight

Instructions on back of certificates. Keep important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history than overworked.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48910 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48910

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 S. Sharp ST.; 7W WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dante Salvatore Bruce

(Residence in Baltimore: No. 500 S. Sharp St.; .....yrs. 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, July 1, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 12 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Domenick Bruce

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Scardina

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Domenick Bruce

(Address) 500 S. Sharp St

15-

[Per Robert P. Harrison]

Filed....., 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Dec. 12, 1920, that I saw him alive on Dec. 11, 1920, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia (Primary)

.....

(Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Eugene L. Pessagno M. D.

Dec. 12, 1920 (Address) 2314 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	12/13, 1920
20-UNDERTAKER	ADDRESS
Fisher Bros	131 E Lexington St

9

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48911

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Chapel ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Bond

(Residence in Baltimore: No. 614 N. Chapel St.; 61 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Nov. 5, 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robert Howe

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abraham Bond

(Address) 614 N. Chapel St

15-

Filed DEC 13 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 24/11/1920, to 12/12/1920, that I saw h[illegible] alive on 11/12/1920, and that death occurred, on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis Hypertrophy

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Mayfield Boyle M. D.

12/12/1920 (Address) 425 N. Carlton St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ashley Cemetery

DATE OF BURIAL, Dec. 14th, 1920.

20-UNDERTAKER Chas L Bailey

ADDRESS 614 Jefferson st

D.48912 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48912

CERTIFICATE OF DEATH.

159

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 114 Albemarle ST. 3 WARD)

2-FULL NAME Chas Sabrecen

(Residence in Baltimore: No. 114 albemarle St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, about 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eileen Sabrecen

(Address) Bank St

15- Robert P. Harrison, JOHNS HOPKINS HOSPITAL
Filed ....., 191.....
Burial Permit Clerk, Registrar.

DEC 13 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry P. Crusby M. D.
(Coroner.)
12/16, 192.. (Address) 6004 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem.

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Wm. K. WOODALL

ADDRESS DEC 18 1920 Jan 24 21

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 48.913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48913

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 W. Cross ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME "Premature" Jordon

(a) RESIDENCE. NO. 206 W. Cross ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE Wh

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/11/20

7 AGE — Years — Months — Days
If LESS than 1 day, 12 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER William Jordon

11 BIRTHPLACE OF FATHER (city or town) St Mary's
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Welch

13 BIRTHPLACE OF MOTHER (city or town) Essex Co
(State or country) Virginia

14 Informant William Jordon
(Address) 206 W Cross

15 Filed DEC 13 1920 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/11, 1920, to 12/11, 1920, that I last saw h... alive on 12/11, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(5 mo. pregnancy)
Expulsion due to maternal illness, (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Severe acute bronchitis
(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Dan'l Franklin, M. D.

12/12, 1920 (Address) 120 W 33d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 13 1920

For Wm E. WOODALL

Burial Permit Clerk.

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14230 D.48914 HEALTH DEPARTMENT—CITY OF BALTIMORE D48914

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Trollinger

(a) RESIDENCE. No. 1013 Hagers Lane ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Jno. Trollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Martha Linton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record (Address) J. H. H.

15 Filed DEC 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1920

17

I HEREBY CERTIFY, That I attended deceased from July 26 1920 to Dec 10 1920, that I last saw h... alive on Dec 10-th 1920, and that death occurred, on the date stated above, at 1450 ... m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency (Luetic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C R Macon, M. D.

XII 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health, Per. Wm. E. WOODALL.	ADDRESS DEC 15 1920

See instructions on back of certificates. Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48915 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48915

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. South Baltimore Gen. Hospital St. 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Meekins.

(a) RESIDENCE. No. 723 Gmidelli's Court WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July ?, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia.

PARENTS

10 NAME OF FATHER George Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Virginia

12 MAIDEN NAME OF MOTHER Mary Meekins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Virginia

14 Informant (Address) John Meekins Rear 723 Gmidelli's Court City

15 Filed DEC 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1920, to Dec. 11, 1920, that I last saw him alive on Dec. 11, 1920, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) 1 yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L. Tolson, M. D.

. 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19

19 UNDERTAKER JOHNS HOPKINS HOSPITAL Commissioner Health

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks. See instructions on back of certificates. Exact statement of OCCUPATION is important. Cause of death must be carefully classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48916 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 Patapsco st Westport ST. 25 WARD) H0

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. McMenamen

(a) RESIDENCE. No. 217 Patapsco st Westport ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McMenamen

6 DATE OF BIRTH (month, day, and year) Dec. 23 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice business 045

(b) General nature of industry, business, or establishment in which employed (or employer) for Self.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William McMenamen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Sarah A. Reside

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary Mc Menamen
(Address) 217 Patapsco st Westport

15 Filed C 13 1920 19 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1920, to Dec 10, 1920, that I last saw h— alive on Dec 9, 1920, and that death occurred, on the date stated above, at 130 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach and Bowels.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) paralysis of bladder

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Raymond Glenn, M. D.

19 (Address) Parkville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec. 14 1920
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

20.48917 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48917

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Varin

(Residence in Baltimore: No. 770 W. Lexington St. St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Canadian Indian	M

6-DATE OF BIRTH, November (Month), (Day), 1887 (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.? 079

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Structural Iron worker.
(b) General nature of industry, business, or establishment in which employed (or employer): (Bridgeman)

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Northwestern Police Desk

(Address) Penna. Ave,

15- Filed DEC 13 1920, 191 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 10, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured of liver, caused by falling about 93 feet while working for Wm. Clintock & Marshall Contracting Co. (accidental) (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Dec. 13, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Curtis Bay, Md.

Former or usual residence Providence, R. I.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Providence R. I.	Dec 13th, 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Balto St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48918 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48918

CERTIFICATE OF DEATH. X74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: ? WARD ?)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Fisher.

(a) RESIDENCE. NO. Back River Road St.: Bengies WARD. Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer) Good

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bengies. Md.

PARENTS

10 NAME OF FATHER Frederick Fisher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Weideran Germany.

12 MAIDEN NAME OF MOTHER Hedwig Kunde.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Weideran Germany.

14 Informant Johns Hopkins Hospital records
(Address)

15 Filed DEC 13 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11- 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 11, 1920, that I last saw him alive on Dec 11, 1920, and that death occurred, on the date stated above, at 545 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

2. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 12/11/20

Was there an autopsy? yes.

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	Dec 14th 1920
20 UNDERTAKER	ADDRESS
Fred Lassahn & Son	Fullerton Md

Note—Items of this certificate are important. See instructions on back of certificates. Insert statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48919 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48919

CERTIFICATE OF DEATH. X 146

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Emory Warren

(a) RESIDENCE. No. Washington D.C. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	~~6~~ 3	8	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Chas. B. Warren

11 BIRTHPLACE OF FATHER (city or town) Chestertown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Olive Turpin

13 BIRTHPLACE OF MOTHER (city or town) Talbot Co.
(State or country) Maryland

14 Informant Mrs. Samuel Moore
(Address) 2106 N. Charles St

15 Filed 19 DEC 13 1920 Registrar

13 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from 12-9-, 1920, to 12-12, 1920, that I last saw him alive on 12-12-, 1920, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Sarcomatus

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Meningitis "Pneumococcic"

(duration) 24 hrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-10-20

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Clinical Manifestations

(Signed) R. H. Richardson, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton, Talbot Co. Md	Dec 15 1920
20 UNDERTAKER	ADDRESS
H. Allen Fuller	3517 Springdale Ave

(1) Insert the word "Yes" or "No" in answering whether operation preceded death, whether there was an autopsy, and whether test confirmed diagnosis. (2) Insert the number of the certificate of occupation. See instructions on back of certificates. (3) Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48920 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48920

CERTIFICATE OF DEATH. 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2607 Fairmount ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman F. Rahyes

(a) RESIDENCE. No. 26 N Fairmount ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) May 24 1852

7 AGE Years 68 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred. F. Rahyes (Address) 432 N. Castle St

Filed DEC 13 1920, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to Dec 12, 1920, that I last saw him alive on 12 11, 1920, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Hardening of Arteries 9028

(duration) 2 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gangrene of foot (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Arthur Thayer M. D.

12/13, 1920 (Address) 2600 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County | DATE OF BURIAL: 12/13 1920

20 UNDERTAKER: William Cook | ADDRESS: 501 6 St

...of certificates. See instructions on back of ce... This is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupatien.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer." etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
Senile gangrene
of foot. Not traumatic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.4.8921 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48921

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary McGuire

(a) RESIDENCE. NO 1800 Harford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick McGuire

6 DATE OF BIRTH (month, day, and year)

7 AGE: about 70 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Europe

PARENTS

10 NAME OF FATHER: John McEagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Mary Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret Kramer

(Address): 429 Hanover

15 Filed ... 19 ... Robert F. Harrison, Registrar

C 13 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1920, to Dec. 12, 1920, that I last saw h[illegible] alive on Dec. 12, 1920, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder or Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Wm. Francis Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 12/16 19

20 UNDERTAKER: Wm Cook

ADDRESS: 50 E Nor[illegible]

Note.—Every important. See instructions on back of certificates. Exact ... Statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Yetta Shochet

D48922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48922

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yetta Schochet Miss

(Residence in Baltimore: No. 21 N. Patterson Park St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Sing'l

6-DATE OF BIRTH, July (Month) 5 (Day) 1902 (Year)

7-AGE, 18 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer): Ldy

9-BIRTHPLACE, (State or Country), Baltimd

PARENTS.

10-NAME OF FATHER, P. S. Chochet

11-BIRTHPLACE OF FATHER (State or Country), Russd

12-MAIDEN NAME OF MOTHER Esther Hethner

13-BIRTHPLACE OF MOTHER (State or Country), Russd

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Balto

15- DEC 14 1920 Filed, 191.. ROBERT B KRAUTER Burial Permit (Registrar)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-6-20 191.., to 12-13-20 191.., that I saw her alive on 12-13-20 191.., and that death occurred, on the date stated above, at 6.10 m.

The CAUSE OF DEATH* was as follows:

Bilateral Salpingitis (Operative

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Adem

(Duration) yrs. mos. ds.

(Signed) Charles H. Levy M. D.

12-13-20, 191.. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 18 yrs. 5 mos. 8 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 21 N Patterson Park Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern Cem — DATE OF BURIAL, 12/14, 1920

20-UNDERTAKER Jack Levis — ADDRESS 1411 E Balto

D48923 HEALTH DEPARTMENT—CITY OF BALTIMORE D48923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 316 N Paca St.) (Ward) 4 79 REGISTERED No. C .....

2-FULL NAME Mrs Pfisterer

(Residence in Baltimore: No. 316 N Paca St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widow

6-DATE OF BIRTH, Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 about yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... clerk 609
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Pfisterer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Hartzell

(Address) 2302 Edgmont Ave.

15- DEC 14 1920 ROBERT J KRAUTER

FILED ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(~~Inquest, autopsy or~~ inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, au-
~~topsy or~~ inquiry.)
.....find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any other

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D.
(Coroner.)

12-14-, 1920 (Address) 117 N Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Dec 15, 19..

20-UNDERTAKER Harlan Fahey & Son ADDRESS 1827 N Howard St

Important. See instructions on back of certificate. Be sure property classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48924

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3923 Park Heights Ave. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Pauline Klingstine

(a) RESIDENCE. No. 3923 Park Heights Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Klingstine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) —— 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Pranke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John S. Klingstine

15 Filed DEC 14 1920 ROBERT P. CHANTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/7/20, 19..., to 12/13/20, 19..., that I last saw h e alive on 12/13/20, 19..., and that death occurred, on the date stated above, at 11 10 P m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis, contributed by Uremia suppression

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia suppression

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/9/20

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Robert B. Wheat M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters Dec 15 192

20 UNDERTAKER — ADDRESS

Martin Baker & Sons 1827 W Baltimore

IION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D48925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48925

CERTIFICATE OF DEATH.

REGISTERED NO. C 48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 N Smallwood St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Bell, Feltus

(Residence in Baltimore: No. 2006 N Smallwood St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct 4, 1866
(Month) (Day) (Year)

7-AGE, 54 yrs. 2 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Frisby.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Feltus

(Address) 2006 N. Smallwood

15- DOBBERT B KRAUTER

Filed DEC 14 1920 191 Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13 1918, to Dec 12 1920, that I saw h alive on Dec 12 1920, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) 3 yrs. mos. ds.

(Signed) Geo. L. Feltus M. D.

DEC 1 1920 191 (Address) 2042 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McCulloch — DATE OF BURIAL, Dec 16, 1920

20-UNDERTAKER Joseph Sayler — ADDRESS 1600 Gay

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48926 HEALTH DEPARTMENT—CITY OF BALTIMORE D48926

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. Visitation Convent Park Ave & Centre St ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Irene. King.

(a) RESIDENCE. NO. Visitation Convent. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 1839.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious. 065

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Rev Mother Aloysius Doonan. (Address) Visitation Convent. Park & Centre Sts.

15 Filed DEC 14 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 13, 1920, that I last saw h alive on Dec 12, 1920, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial weakness &
Senile senility

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings & autopsy

(Signed) Charles O'Connor M. D.

Dec 15 1920 (Address) 6 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	DEC 15 1920
20 UNDERTAKER	ADDRESS 2236 W. Baltimore St.
Wm J Hartwell	

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 48927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48927

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 Foster Ave. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Boehm.

(a) RESIDENCE. NO. 3305 Foster Ave. ST. 26. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ooo

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Boehm

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Botterweich

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.MD.
(State or country)

14 Informant John Boehm
(Address) 3305 Foster Ave.

15 Filed OCT 4 1920 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.11 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/10 19 20, to 12/10/20 19....,
that I last saw h.....alive on....., 19.....,
and that death occurred, on the date stated above, at 12 A. m.
The CAUSE OF DEATH* was as follows:

ooo

Broncho pneumonia

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Glenn M. D.

(Address) 633-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Dec.14 1920

20 UNDERTAKER: Lilly & Zeiler.

ADDRESS: 403S. Wolfe St

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48928

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. First, Brooklyn, 25 WARD)

2-FULL NAME William F Arnold

(a) RESIDENCE. No. 18 N. First ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lucy E.

6 DATE OF BIRTH (month, day, and year) July 8 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter Oil

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lucy E Arnold

(Address) 18 N. First St Brooklyn

15 Filed DEC 14 1920 ROBERT P KRAUTER Registrar

Burial Permit 01844

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) Dec 11 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1920, to Dec 11, 1920, that I last saw h.. alive on Dec 11, 1920, and that death occurred, on the date stated above, at 11.46 P. m.,

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam & urine

(Signed) J Harry Ziris, M. D.

12/12 1920 (Address) 1508 Hollyrood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL	DEC 14 1920

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

Note.—Very important. See instructions on back of certificates. OCCUPA.

D48929

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D48929

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1518 Henry St. St.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Andrew S. Rogers.

(Residence in Baltimore: No. 1518 Henry St. St.: 60 yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower.

6 DATE OF BIRTH: Do not know. (Month), 1 (Day) (Year)

7 AGE: 69 yrs. --- mos. --- ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Painter.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): New York.

PARENTS

10 NAME OF FATHER: James Rogers.

11 BIRTHPLACE OF FATHER (State or country): New York.

12 MAIDEN NAME OF MOTHER: Harriett.....

13 BIRTHPLACE OF MOTHER (State or country): New York.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Foster, (nephew)

(Address) 1518 Henry St.

15 DEC 14 1920, 191

LOWELL B KRAUTER
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 12th. 1920., 191 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 21st. 1920, 191, to Dec 12th. 1920, 191, that I saw him alive on Dec 12th. 1920., 191, and that death occurred, on the date stated above, at 8. 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ... yrs. ... mos. 21 ds

Contributory (SECONDARY): Exhaustion.

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.

Dec 13th., 1920. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 14, 1920

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48930

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1819 W Fayette ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Agnes Cunaler

(a) RESIDENCE. No. 1819 W Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Cunaler

6 DATE OF BIRTH (month, day, and year) Apr 7 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. W. Cathcart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Delbert Cathcart

(Address) 1819 W Fayette St

15 Filed DEC 14 1920 ROBERT I. KRAUS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 11 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1920, to Dec 11, 1920, that I last saw h.e alive on Dec 11, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry S McCarty, M. D.

, 19 (Address) 37 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	12/15/20
20 UNDERTAKER	ADDRESS
George E Farley	Fulton & Fayette

TION is very important. See instructions on back of certificates. So that it may be properly classified. Exact statement of OCCUPA-

Spec.—5-19-13—M. & T.—500 Bks.

D 48931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48931

CERTIFICATE OF DEATH.

9

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Wolfe ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Hulker

(Residence in Baltimore: No. 915 Wolfe st. St.; 1 yrs., 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) ~~Single~~

6-DATE OF BIRTH, Aug 27, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos V Hulker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Zimmer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos V Hulker

(Address) 915 Wolfe St

15-

Filed DEC 14 1920 ROBERT E KRAUTER

191.....Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 14 1920, that I saw her alive on Dec 14 1920, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration).....yrs.....mos...2...ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) H. J. Steudel Jr. M. D.

Dec 14, 1920 (Address) 632 Harlem ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Dec 14 1920

20-UNDERTAKER Chas J Zimmer — ADDRESS 1x x 24 Gay

D 48932 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48932

CERTIFICATE OF DEATH.

15 D

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Kimmerle

(Residence in Baltimore: No. 330 S Eastern St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 20 (Day), 1867 (Year)

7-AGE, 53 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 53

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Henry Lieber

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Barb. Alt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. I. Kimmerle

(Address) 3305 Eastern

15-

Filed DEC 14 1920 ROBERT F. KRAUSE Deputy Clerk Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Carbolic Acid poisoning

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ill health

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Dec 13, 1920 (Address) 1039 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Dec. 14, 1920

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Eutaw St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48933

91-089

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Hilker

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address): New City Hospital

15 Filed DEC 14 1920 ROBERT J. KRAUTER Registrar

12/13/20

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to December 13 1920, that I last saw h er alive on December 12, 1920, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis.
(No cerebral tumor-
Usage)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneu-
monia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) V. Bosserman, M. D.

(Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cemetery	Dec 15 1920
20 UNDERTAKER	ADDRESS
N. Sander & Son	1710 Fleet St

Note.—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

Over

D 48934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 48934

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 403 Wilson ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Carroll

(a) RESIDENCE. No. 403 Wilson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Carroll

6 DATE OF BIRTH (month, day, and year) Dec 3-1872

7 AGE 54 Years 8 Months 12 Days | If LESS than 1 day, hrs. or mln.

48 - 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of Industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George H. Carroll
(Address) 403 Wilson St

15 Filed DEC 14 1920 ELLET B. LAUTER Registrar
Special Permit Order

12/17/1920 GG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/12, 1920, to 12/13, 1920, that I last saw h alive on 12/13, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.
+ Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. M. Lauter, M. D.

, 19 (Address) 1139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn Cem | DATE OF BURIAL: Dec 16 1920

20 UNDERTAKER: George H. Holland | ADDRESS: 1631 Harlem

Hillcan

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Baltimore, Md., December 17, 1920.

I do hereby make oath that the age of deceased, Martha E. Carrol
given on Baltimore City Certificate of Death - D-48934, as 51 years, 8 mon
and 12 days in incorrect and that same should be 48 years and 10 days;
date of birth being December 3d, 1872.

B Lee Kluttz

Physician.

Subscribed and sworn to before me this 17th day of December, 192

Reed Gaither

Notary Public

Spec.—8-24-14—M. & T.—2000 Blks.

D 48935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Etting ST.; 14 WARD) REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel R. Johnson

(Residence in Baltimore: No. 1924 Etting St. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept 10th (Month) (Day), 1850 (Year)

7-AGE 70 yrs. 3 mos. 2 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Invalid

9-BIRTHPLACE, (State or Country), Chestertown Md

PARENTS.

10-NAME OF FATHER, John Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Johnson

(Address) 1924 Etting St

15- ROBERT B KRAUTER

Filed DEC 14 1920 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10th 1920, to Dec 12 1920, that I saw h-er alive on Dec 10th 1920, and that death occurred, on the date stated above, at 8.15P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harriett Brown M. D.

Dec 13th, 1920. (Address) 15 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Hyattsville Md

DATE OF BURIAL, Dec 15, 1920

20-UNDERTAKER George H. Holland

ADDRESS 1631 Hanna Place

Spec.—8-24-14—M. & T.—2000 Blks.

Dr Hooper
1301 Patterson Park Ave

1920
1893
27

1048936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-091 1048936

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Bartlett ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr Thos F Cooper

(Residence in Baltimore: No. 718 Bartlett St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	single

6-DATE OF BIRTH, July 14th, 1893
(Month) (Day) (Year)

7-AGE. 27 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Doctor
(b) General nature of industry, business, or establishment in which employed (or employer): 809

9-BIRTHPLACE, (State or Country). St Marys Co Md

PARENTS.

10-NAME OF FATHER. John L Cooper

11-BIRTHPLACE OF FATHER (State or Country). St Marys Co Md

12-MAIDEN NAME OF MOTHER Annie M Veach

13-BIRTHPLACE OF MOTHER (State or Country). St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Cooper

(Address) 718 Bartlett St

15- Filed DEC 14 1920, 191.....

ROBERT N KRAUTER
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 14 1920, that I saw h[illegible] alive on Dec 14 1920 and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

1 Bronchial Pneumonia
Duration ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza complicating pregnancy
Duration ..... yrs. ..... mos. 14 ds.

(Signed) W. L. Cooper M. D.

Dec 14, 1920 (Address) 1301 Pat Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Dec 16, 1920

20-UNDERTAKER Martin Fahey & Son — ADDRESS 827 W Pratt St

048937 HEALTH DEPARTMENT--CITY OF BALTIMORE 048937

CERTIFICATE OF DEATH

92-28

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2207 Baker ST.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Abram G Nusbaum

(Residence in Baltimore: No. 2207 Baker St St.: 3 yrs. mos. ds.)

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH Jan 5, 1916 (Month) (Day) (Year)

7 AGE 4 yrs. 11 mos. 8 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Nusbaum

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Routson

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Nusbaum

(Address) 2207 Baker St

15 DEC 14 1920 ROBERT J KRAUTER
Filed ..... 191 ..... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 13, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1920, to Dec 13 1920, that I saw him alive on Dec 13, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds

Double Pneumonia-Lobar

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. 1 day ds.

(Signed) Dr E Miles Woodward M. D.

12-13-, 1920 (Address) 2129 Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baust Church Catonsville Md | DATE OF BURIAL Dec 15 1920

20 UNDERTAKER W M Routson | ADDRESS 230 N Greene

Spec.—6-9-19—H. P. Co.—1000 Blks.

648938

HEALTH DEPARTMENT—CITY OF BALTIMORE

648938

CERTIFICATE OF DEATH.

1 42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N. Central ave, ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Brown

(a) RESIDENCE. No. 529 N. Central ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Geo. Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER John Stephany

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Harris Brown.
(Address) 529 N. Central ave.

15 Filed DEC 14 1920

ROBERT I. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1920, to Dec. 11, 1920, that I last saw her alive on Dec. 11, 1920, and that death occurred, on the date stated above, at 6-25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Diagnosis made at John Hopkins

(Signed) Robert J. Green, M. D.

(Address) 120½ Aisquith St. DEC-13, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	12/16/20

20 UNDERTAKER Theodore Whitt ADDRESS 113 S. Wolfe St.

Sec. 4, Rule 7. Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 48939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 48939

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Cumberland ST.; 15 WARD)

2-FULL NAME William Earle Baltz

(a) RESIDENCE. No. 604 Cumberland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. 11 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 650

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William F. Baltz

11 BIRTHPLACE OF FATHER (city or town) City
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dietle

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country) Md

14 Informant William F. Baltz
(Address) 604 Cumberland

15 Filed DEC 14 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 13, 1920, that I last saw him alive on Dec 13, 1920, and that death occurred, on the date stated above, at 4:15 P.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. E. Jones, M. D.

. 19 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 15 1920
20 UNDERTAKER	ADDRESS
Geo Weber & Son	2503 Edmondson ave

Instructions on back of certificates. Statement of OCCUPA

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48940 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48940

CERTIFICATE OF DEATH. X 104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Calvin Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Prosser Miles

(Residence in Baltimore: No. 403 Calvin Ave St.; ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH October 13th, 1919
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. 0 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Detroit Mich.

PARENTS.

10-NAME OF FATHER, Joseph Miles.

11-BIRTHPLACE OF FATHER (State or Country), Canada.

12-MAIDEN NAME OF MOTHER Jane Bellock

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Miles

(Address) 403 Calvin ave

15-

DEC 14 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF ~~DEATH~~ December 13th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13th 1920, to Dec 13th 1920, that I saw ~~her~~ alive on Dec 13th 1920 and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Diab

..... (Duration) ..... yrs. ..... mos. ? ds.

(Signed) ..... M. D.

Dec 13th, 1920. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity — DATE OF BURIAL, 12/15/20, 191.

20-UNDERTAKER William Cook — ADDRESS 502 E. North Ave

(over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48941

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital 91

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Robertson

(a) RESIDENCE. No. 347 E. 27th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Robertson

6 DATE OF BIRTH (month, day, and year) Unknown 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed DEC 14 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1920, to Dec. 13, 1920, that I last saw h. im alive on Dec. 12, 1920 and that death occurred, on the date stated above, at 4 45 m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia + Delirium (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) H. Friedenwald, M. D.

12/14/1920 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 12/16/1920

20 UNDERTAKER William Cook

ADDRESS 532 E. Lafayette Ave

IRON is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48942 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48942

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 E. Grindall ST.: 24th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Shugars

(a) RESIDENCE. No. 415 E. Grindall ST., 24th WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Shugars

6 DATE OF BIRTH (month, day, and year) Aug 30, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William D. Shugars

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Louisa Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Wm D. Shugars

(Address) 415 E. Grindall

DEC 14 1920 Filed 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1920, to December 13, 1920, that I last saw him alive on December 13, 1920, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx and contiguous structures.

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laryngoscopic Examination

(Signed) Henry F. Buettner, M. D.

19 (Address) 1017 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A a Co

DATE OF BURIAL 12/15 1920

20 UNDERTAKER Wm Cook

ADDRESS 5010 Nor Ave

Form is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48943

152

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womens Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Dowdley

(Residence in Baltimore: No. 2222 N. Charles St.; ....yrs.,....mos.,....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, December 14, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 0 ds. If LESS than 1 day, ½ hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Felix Raymond Dowdley

11-BIRTHPLACE OF FATHER (State or Country), Maad.

12-MAIDEN NAME OF MOTHER Anna Ruth Amos

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (Father.) Felix Raymond Dowdley

(Address) 2222 N. Charles

15-

Filed ....., 1920 Robert P. Harrison,

....., 191.... Registrar.

C14 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1920, to Dec. 14, 1920, that I saw h[illegible] alive on Dec. 14 1920, and that death occurred, on the date stated above, at 9 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs. ....mos. 0 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Dec. 14, 1920 (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	12/15...., 1920
20-UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	05 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 48944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48944

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lutherville on Bel. T. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Woods

(a) RESIDENCE. NO. Preston & Valley Sts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Woods

6 DATE OF BIRTH (month, day, and year) unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Zila

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Clarissa Country

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence (Address) Preston & Valley Sts

15 Filed DEC 14 1920 19 Robert P. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw her alive on Dec 13, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gastric hemorrhage (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cord (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D.

Dec 14 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec 15 1920

20 UNDERTAKER H. C. Widefield ADDRESS 914 Gruman Ave

TION IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable Cancer of Stomach.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48945 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48945

CERTIFICATE OF DEATH. X 105

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Frazier al

(Residence in Baltimore: No. 412 Eagle, Belair Md. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Black	Married

6-DATE OF BIRTH. ....., 1876
(Month) (Day) (Year)

7-AGE. 44 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

9-BIRTHPLACE, (State or Country), Cape May, New Jersey.

PARENTS.

10-NAME OF FATHER, John N. Frazier

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. J. Sweeney

(Address) Md. State Penitentiary.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

OCT 14 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 23 1920, to December 9 1920, that I saw him alive on December 9 1920, and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia - Exhaustion - Cardiac Failure - Shock

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Gastro - Enteritis

(Duration) ....yrs. ....mos. 17 ds.

(Signed) William F. Schwartz M. D.

Dec. 10, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 9 mos. 13 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Belair, Md.

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL, DEC 14 1920, 191...

20-UNDERTAKER Commissioner Health, ADDRESS

Wm. F. WOODALL.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48946

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3057 Stafford. ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bryant

(a) RESIDENCE. NO. 3057 Stafford ST., 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 20

6 DATE OF BIRTH (month, day, and year) Dec. 12-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Pigott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs E Bryant

(Address) 3057 Stafford St

15 Filed DEC 14 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Dec 14, 1920,

that I last saw h[illegible] alive on Dec 13, 1920,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A Knell, M. D.

12/14, 1920 (Address) 4207 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 16 1920
20 UNDERTAKER	ADDRESS
H W Cook	N Gay St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D.48947 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48947

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 Louden ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Ransone

(Residence in Baltimore: No. 105 S. Calhoun St.; 27 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb. (Month) 23 (Day), 1857 (Year)

7-AGE, 63 yrs. 9 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Dietrich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Stelbrich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. B. Ransone

(Address) 133 Louden Ave

15-

Filed DEC 14 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1920, to Dec 1920, that I saw her alive on Dec 12 1920, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(Duration) 10 yrs. mos. ds.

(Signed) H Kemerhough M. D.

12/13/20, 192.. (Address) 3720 Pk Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 14, 1920

20-UNDERTAKER George Schwab & Bro — ADDRESS 1116 Pulaski Ave

See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48948

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3317 Foster Ave ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Goeller

(a) RESIDENCE. NO. 3317 Foster Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Goeller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Goeller
(Address) 3317 Foster Ave.

15 Filed Robert P. Harrison, Registrar
DEC 14 1920
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2nd, 1920, to Dec. 12th, 1920, that I last saw him alive on Dec. 11th, 1920, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) - yrs. - mos. 1 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Townsend, M. D.

12/14, 1920 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 15 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	403 S. Wolfe St.

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D.48949 HEALTH DEPARTMENT--CITY OF BALTIMORE D.48949

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 22 N. Hamburg st. ST.: 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ephraim L. J. Tressel.

(Residence in Baltimore: No. 22 N. Hamburg st. St.: 46 yrs. ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male.	White.	Married.

6 DATE OF BIRTH: August 10th. 1844 (Month) (Day), 1 (Year)

7 AGE: 76 yrs. 3 mos. 26 ds. — If LESS than 1 day, ... hrs. or ---- min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clergyman. 018
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Tuscarawis Co. Ohio

PARENTS

10 NAME OF FATHER: Samuel Tressel.

11 BIRTHPLACE OF FATHER (State or country): Ohio.

12 MAIDEN NAME OF MOTHER: Elizabeth Starks.

13 BIRTHPLACE OF MOTHER (State or country): Ohio.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Tressel. (wife)

(Address) 22 N. Hamburg st.

15 Filed DEC 14 1920, 191

Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 12th. 1920. (Month) (Day), 191 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2nd. 1920. 191 ..., to Dec 12th. 1920 191 ..., that I saw him alive on Dec 12th. 1920. 191 ..., and that death occurred, on the date stated above, at 10. 40 m.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and kidneys.

(Duration) ..... yrs. 2 mos. ..... ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.

Dec 13th, 1920. (Address) 1017 E. Charles st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: 12-15th, 1920

20 UNDERTAKER: Wm Chas A. G. Rohde — ADDRESS: 600 Washington Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION as very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048950 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048950

CERTIFICATE OF DEATH. X 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 E 23 det. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorthory M. Jones

(a) RESIDENCE. NO. 318 E 23 det ST., WARD. Detroit-Michigan
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. 14 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept. 15 1920

7 AGE — Years: — Months: 2 Days: 27 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Detroit Mich

PARENTS

10 NAME OF FATHER: Harry Lee Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): D. C

12 MAIDEN NAME OF MOTHER: Rhoda Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Columbia S. C

14 Informant: Harry Lee Jones
(Address) 318 E. 23 St.

15 DEC 15 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1920, to Dec. 12, 1920, that I last saw h[illegible] alive on Dec 12, 1920, and that death occurred, on the date stated above, at 8:10 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
(Secondary) gestion & Collapse (Duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Hall, M. D.

, 19 (Address) 1926 E 23rd St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Dec 15 1920

20 UNDERTAKER: Geo. H. Hall

ADDRESS 378 N Bdle

IION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48951 HEALTH DEPARTMENT—CITY OF BALTIMORE D48951

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH Robert Garrett Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Wehn

(a) RESIDENCE. No. 2001 Clifton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas A. Wehn

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Carrie M. Bates

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Thomas A. Wehn
(Address) 2001 Clifton Ave

DEC 15 1920 ROBERT E. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th 1920, to Dec 13th, 1920, that I last saw her alive on Dec 13th, 1920, and that death, occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Chemical

(Signed) J. W. Clift, M. D.

Dec 13 1920 (Address) 27 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 15 1920
20 UNDERTAKER Deaf Smith	ADDRESS 1000 Fairmount Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48952

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 E North Ave. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie A. Evans

(a) RESIDENCE. No. 1110 E North Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) August 8/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Deals Island Md

PARENTS

10 NAME OF FATHER John W. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Deals Island Md

12 MAIDEN NAME OF MOTHER Mary L. Dix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md

14 Informant (Address) M. A. L. Evans 1110 E North Ave

15 DEC 15 1920 ROBERT I. KRAUTER Registrar

Vegetable 2031 Eutaw Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr. 16 to Dec 13, 1920.

that I last saw h... alive on Dec 13, 1920.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

C. Apoplexy — Primary 1 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Nephroma — 5 yrs. — mos. — ds.

(duration)

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Traynor M. D.

, 19 (Address) 202 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 16 1920

20 UNDERTAKER ADDRESS

Welsh & Lack 502 E North Ave

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48953 HEALTH DEPARTMENT—CITY OF BALTIMORE D48953

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5009 O'Donnell ST.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Foster

(Residence in Baltimore: No. 5009 O'Donnell St. Sh. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, Nov 28, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles H Foster

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nettie V. Watson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Foster

(Address) 5009 O'Donnell St.

15- Filed DEC 15 1920 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28 1920 to Dec 13 1920.

that I saw h.. alive on Dec 13 1920.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Premature birth

prob. interd gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) L. A. Mankowski M. D.

Dec 17, 1920 (Address) 3035 O'Donnell St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Dec 15, 1920.

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Eden St.

See instructions on back of certificate.

Gaskin

Spec.—8-24-14—M. & T.—2000 Bks.

D48954 HEALTH DEPARTMENT—CITY OF BALTIMORE D48954

CERTIFICATE OF DEATH.

X 64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1428 Riggs av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Gaskin

(Residence in Baltimore: No. 1428 Riggs av 3 wks St.; ....yrs., ...mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. ....Unknown...., 184..
(Month) (Day) (Year)

7-AGE, ..73.. yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, Isaac Holly

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Holly

(Address) 10 McTavish

15- DEC 15 1920 ROBERT E. LEAUTER

Filed....., 191.... Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Dec. 14...., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1920, to Dec 11 1920, that I saw her alive on Dec 13 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

.....Apoplexy.....

.....

.....

.....(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) Blood Clot

.....(Duration).....yrs.....mos.....ds.

(Signed) ....John Duncan.... M. D.

Dec. 14, 1920 (Address) 1000 Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Norfolk Va	Dec. 15, 1920
20-UNDERTAKER	ADDRESS
Sam'l. W. Chase Son	1400 Mosher

D 48955 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 48955

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1777 E Fayette St ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Jenkins

(Residence in Baltimore: No. 1777 E Fayette St ST.: 2 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 14, 1918
(Month) (Day) (Year)

7-AGE, 2 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Clarence E. Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence E Jenkins

(Address) 1777 E Fayette St

15-

Filed DEC 15 1920, 191 ROBERT E KRAUTER

Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clarence E Jenkins M. D.
(Coroner)

Dec 14 1920 (Address) 1500 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Dec 16 1920
20-UNDERTAKER	ADDRESS
Jack Levi	141 E Baltimore

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48956

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 E. Fairmount ave ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Moelter

(a) RESIDENCE. NO. 2214 E. Fairmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Anton Moelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Anna B. Vogelsang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Miss Mary Moelter
(Address) 2214 E. Fairmount

15 Filed DEC 15 1920 ROBERT J. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 20, to Dec 13, 19 20,

that I last saw h[illegible] alive on Dec 13 19 20

and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Bright Hemiplegia

(duration) 2 mos.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) 3 yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Special Exam.

What test confirmed diagnosis?

(Signed) G E Glades, M. D.

(Address) 143 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 16 1920
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Luzerne

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

39 D48957

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 S. Castle St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grebe

(a) RESIDENCE. No. 109 S. Castle St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE: 66 (Years / Months / Days)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Henry Grebe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Gattman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant (Address): Miss Mary E. Grebe 109 S. Castle

15 Filed DEC 15 1920 ROBERT L. SLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1920, to Dec 13 1920, that I last saw him alive on Dec 13, 1920 and that death occurred, on the date stated above, at 4 AM.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Microscopic

What test confirmed diagnosis?

Dec 13 1920 (Signed) J. C. Slade, M. D.
(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec. 16 1920

20 UNDERTAKER: J. J. Herr — ADDRESS: 156 N. Luzerne

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D48958

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 418 S. East ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward M. Kane

(a) RESIDENCE. No. 418 S. East ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Kane

6 DATE OF BIRTH (month, day, and year) Jan 25th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Suff. in 086

(b) General nature of industry, business, or establishment in which employed (or employer) canning Estb

(c) Name of employer Langrall Bros

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Patrick Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Martin Kane

(Address) 418 S. East ave.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 8, 1920, to Dec 13, 1920, that I last saw him alive on Dec 12, 1920, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic & Mitral Insufficiency

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Carl Eschmann, M. D.

, 19 (Address) 340 S East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	12/16 1920
20 UNDERTAKER John A. Moran	ADDRESS 300 E Balto St.

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48959

CERTIFICATE OF DEATH.

5 19

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 N Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hinton

(a) RESIDENCE. NO. 621 N Spring St., WARD.....
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hinton

6 DATE OF BIRTH (month, day, and year) Dec 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	50	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Hinton (Address) 621 N Spring St

15 DEC 15 1920 ROBERT L. KLAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1920, to Dec 12, 1920, that I last saw h.. alive on Dec 11, 1920, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) J. Edward Fisher, M. D

12-14-20 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Dec 15 1920
20 UNDERTAKER Mrs Robt a Flett	ADDRESS 1725 Ashland Ave

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48960 HEALTH DEPARTMENT—CITY OF BALTIMORE D48960

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3238 Foster Ave ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O'Hara

(a) RESIDENCE. NO. 3238 Foster ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of John O'Hara

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 39 — Months: — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John H Ruth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Christina Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John J O'Hara
(Address): 3238 Foster Ave

15 Filed DEC 15 1920 ROBERT P. FRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Dec 13, 1920, that I last saw h.. alive on Dec 12, 1920, and that death occurred, on the date stated above, at 11 P.c. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

12/14 1920 (Address) 839 O. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 16 1920

20 UNDERTAKER: Randall Apple Son — ADDRESS: 318 Dan

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48961

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 955 Harford Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret K. Murphy

(a) RESIDENCE. No. 955 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year): Nov 10, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward Leuller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dawn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Elizabeth A. Murphy
(Address) 955 Harford Ave

15 Filed DEC 15 1920 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 5. 1920 to Dec 12. 1920.

that I last saw her alive on Dec 12. 1920.

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

OVW

Acute nephritis.
To my personal knowledge
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Uremic Coma
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Nitric acid & heat

(Signed) Mary F Voegtlen, M. D.

Dec 14, 1920 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 16 1920

20 UNDERTAKER: Elmer H. Copeland ADDRESS 924 E. Eager

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition. Probably cold. Also very old.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 20 D48962

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Bay View Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Billy Spurgeon Matthews

(a) RESIDENCE. No. 336 N. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lewerals

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp Reports (Address)

15 Filed DEC 15 1920 ROBERT B. LAMOTHE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 14, 1920, that I last saw h.im alive on Dec 13, 1920, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Septicemia

Infected finger. Cause not known

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Excitement

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) Wm G. C. Medairy M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenberg Va.	Dec 15 1920
20 UNDERTAKER	ADDRESS
Samuel H. Ensley	W. Biddle

MPORTANT is very important. See instructions on back of certificates.

D48963 HEALTH DEPARTMENT—CITY OF BALTIMORE D48963.

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Curtis Ave & Cypress St Curtis Bay ST. 25 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Skuszka.

(Residence in Baltimore: No. 5 Cypress St Curtis Bay. St.: 7 yrs., 3 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, August 25th. 1913, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
7 yrs. 3 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Onofrey Skuszka.

11-BIRTHPLACE OF FATHER (State or Country), Austria.

12-MAIDEN NAME OF MOTHER Jawdocka Papisz.

13-BIRTHPLACE OF MOTHER (State or Country), Austria..

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Onofrey Skuszka. (father)

(Address) 5 Cypress St. Curtis Bay.

15- ROBERT J. KRAUTER

Filed DEC 15 1920 By..... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12th. 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the head and body.
Accidentally struck and run over by
car #682 of U. Ry & E. Co.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Wm. Rembrandt M. D.
(Coroner.)

Dec 14, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross A.M.E.	Dec 15 1920
20-UNDERTAKER	ADDRESS
M. F. Hackwood	Midland

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48964

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH General German Aged People Home REGISTERED NO.....

CITY OF BALTIMORE: (No. N E Cor Balto Payson ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Hurbig

(a) RESIDENCE. No. N E Cor Balto Payson ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 8 mos. ds. How long in U. S., if of foreign birth? 63 yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Frederick Hurbig

6 DATE OF BIRTH (month, day, and year) Jan 27 1833

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... mln.
87	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Neumunster
(State or country) Germany

PARENTS

10 NAME OF FATHER Johan Hurbig

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Betty Zudeck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Records of German Aged Home
(Address) Baltimore Payson St.

15 Date received DEC 15 1920 REGISTRAR'S BUREAU
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1920, to Dec 12, 1920, that I last saw h[illegible] alive on Dec 10th, 1920, and that death occurred, on the date stated above, at 5 45a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Rheumatism 2 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) John Hauch, M. D.

17/13, 1920 (Address) 1140 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Dec 15 1920
20 UNDERTAKER	ADDRESS
Jos B Cook	1033 Balto

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120-091 D48965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1336 Druid Hill Ave (Ward) 17

2-FULL NAME Harry F Stewart

(a) RESIDENCE. No. 1336 Druid Hill Ave Ward.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 54 yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Teresa Stewart

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stroppel Bros.

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Unknown Crabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Teresa Stewart.

(Address) 1336 Druid Hill Ave

15 DEC 15 1920 ROBERT E LAZZATER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1920, to Dec 13, 1920; that I last saw him alive on Dec 12, 1920, and that death occurred, on the date stated above, at 2:15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uraemia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uranalysis

(Signed) Joseph William Petty, M. D.

Dec 14 1920 Address) 2227 Eutaw Place Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Dec 15 1920

20 UNDERTAKER Harwood Huxley

ADDRESS 578 W Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48966 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D48966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.; 4 WARD) X 78

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucille Sands

(Residence in Baltimore: No. Marriottsville Md. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	SINGLE

6-DATE OF BIRTH. Unknown, 1902
(Month) (Day) (Year)

7-AGE. 18 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Sands

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sallie Groones

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Sands

(Address) Marriottsville Md

15- Filed DEC 15 1920 ROBERT B KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 14 1920, to December 14 1920, that I saw h.. alive on December 14 1920, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Septicemia & Acute Endocarditis

(Duration) ....yrs. ....mos. 14(?) ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Jno Hundley Jr. M. D.

191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence Marriottsville Md

19-PLACE OF BURIAL OR REMOVAL, Cockeysville Md — DATE OF BURIAL, Dec 17, 1920

20-UNDERTAKER Jas R Deer — ADDRESS Cockeysville Md

Do not write anything on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48967 HEALTH DEPARTMENT—CITY OF BALTIMORE D48967

CERTIFICATE OF DEATH.

REGISTERED NO. 15 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Erby

(a) RESIDENCE. No. 1622 Presstman St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records
(Address): New City Hospital

15 Filed DEC 15 1920 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13, 19 20

17 I HEREBY CERTIFY, That I attended deceased from December 1, 19 20, to December 13 19 20.

that I last saw her alive on December 13, 19 20.

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) M Bberman M. D.

12/13/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn.	Dec 16 1920
20 UNDERTAKER	ADDRESS
JAMES H. BERRY	1303 PRESTMAN ST.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Cause of death must be properly classified.

Ryoza Sasaki

Spec.—6-9-19—H. P. Co.—1000 Bks.

48968

HEALTH DEPARTMENT—CITY OF BALTIMORE

48968

CERTIFICATE OF DEATH.

X102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R. Sasaki

(a) RESIDENCE. No. S.S. Yonei Maru ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Japanese

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): O15

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Japan

PARENTS

10 NAME OF FATHER R Sasaki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Japan

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Japan

14 Informant (Address)

15 Filed ..... 19 ..... Registrar

DEC 15 1920 ROBERT P. CARTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/13, 1920, to 12/14, 1920, that I last saw h alive on 12/14, 1920, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gravel Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 12/14

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. D. Ridgely, M. D.

12/14/1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 16 1920
20 UNDERTAKER E. Levinson & Bro	ADDRESS 1127 E Baltimore St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Ryōgō

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48969

64

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 N. Howard ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen A. Carroll

(Residence if Baltimore: No. 708 N. Howard St ST.: 65 yrs., 4 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, August (Month) ..... (Day) ....., 1857 (Year)

7-AGE, 63 yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 686

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Wm Kelly.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary White.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Carroll

(Address) 708 N. Howard St

15-

Filed DEC 15 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2nd 1920, to Dec 13th 1920, that I saw her alive on Dec 13th 1920, and that death occurred, on the date stated above, at 1.30 4m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Oedema

.....

..... (Duration) ?.... yrs. ?.... mos. 5 ds.

CONTRIBUTORY (Secondary) Hemiplegia Apoplectic ?

..... (Duration) ..... yrs. 6 mos. ? ds.

(Signed) Joseph B Saunders M. D.

Dec 15th, 1920 (Address) 719 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	Dec 16, 1920
20-UNDERTAKER	**ADDRESS**
H. C. Wedefeld & Co	414 Greenmount Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48970

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Hawthorn Road ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Farran Mitchell

(a) RESIDENCE. NO. 201 Hawthorn Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. Calvin Mitchell

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joseph F. Farran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburg Pennsylvania

12 MAIDEN NAME OF MOTHER Pauline V. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant J. Calvin Mitchell

(Address) 201 Hawthorn Road, R. P.

15 Filed DEC 15 1920, 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1920

17

I HEREBY CERTIFY, That I attended deceased from December 13, 1920, to Dec 14, 1920, that I last saw h[illegible] alive on December 14, 1920, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible] of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar in urine Fehling's

(Signed) Jos. W Bishop, M. D.

, 19 (Address) 701 Sheridan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/16 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates. ...ay be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~144625~~ 20.48971 — 20.48971

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: (Ward) 9 11

2-FULL NAME (1) Boy Burrell 2nd born

(a) RESIDENCE. No. 305 S Dallas St. Balto. 2nd WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 10 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colrd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER ? Burrell

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lrah ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant J. H. Hosp. records
(Address)

15 Filed DEC 15 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1920, to Dec 12, 1920, that I last saw him alive on Dec 12, 1920, and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? ...

What test confirmed diagnosis? None

(Signed) W. P. Davison, M. D.

, 19 (Address) J. H. H. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health, DEC 15 1920

WM. S. WOODALL.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48972 HEALTH DEPARTMENT—CITY OF BALTIMORE 48972

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 127 N. Cross ST.: 23 WARD)

2-FULL NAME M. Agnes Lingner

(a) RESIDENCE. No. 127 N. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? 53 yrs. 11 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Geo. F. Lingner, Jr.

6 DATE OF BIRTH (month, day, and year) Jan. 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Owings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Jane Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Geo. F. Lingner (Address) 127 N. Cross St.

15 Filed DEC 15 1920 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec 13, 1920, that I last saw h[illegible] alive on Dec 12, 1920, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

Flem (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Chambers, M. D.

1716 E. Pendleton St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	19

20 UNDERTAKER Margaret D. Flynn

ADDRESS 1732 Eighth

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48973 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48973

CERTIFICATE OF DEATH.

100-079

1-PLACE OF DEATH Womans Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette & John ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burdette Haile

(Residence in Baltimore: No. 1308 Valley St.: 12 yrs., 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 29 (Day), 1908 (Year)

7-AGE, 12 yrs. 6 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Maryland.

PARENTS.

10-NAME OF FATHER, Thos. J. Haile

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Nellie Doran

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman E Tannenbaum

(Address) Womans Hospital

15-

Filed DEC 15 1920, 19.., Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Dec 13 1920, that I saw her alive on Dec 13 1920, and that death occurred, on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation - Tonsillectomy

Chronic tonsillitis (Duration) 5 yrs. mos. ds.

(Signed) Emil Deutschmann M. D.

Dec. 13, 1920 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Md. DATE OF BURIAL, Dec 16 1920

20-UNDERTAKER Margaret G. Flynn ADDRESS 424 N Eighth St.

Instructions: Use typewriter. Last sentence of OCCUPATION is very important. See instructions on back of certificate.

D.48974 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48974

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital 70 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura H. Kimball

(Residence in Baltimore: No. 508 N Fulton ave St. (yrs. 12 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, ... May (Month) 13 (Day), 1903 (Year)

7-AGE, 17 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper 208
(b) General nature of industry, business, or establishment in which employed (or employer): Piano Salesroom

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles S Kimball

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna M. Hebbl

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph Pass

(Address) 1515 W Lafayette st

15- DEC 15 1920 ....., 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Base of Skull
Auto Accident

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration) .....yrs. .....mos. 1 ds.

(Signed) James H Hamilton M. D.
(Coroner.)

Dec 18, 1920 (Address) 200 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State 12 yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? Fulton ave & Mulberry St.

Former or usual residence 508 N Fulton ave

19-PLACE OF BURIAL, OR REMOVAL, Mt. Olivet Cem — DATE OF BURIAL, Dec 17, 1920

20-UNDERTAKER Margaret A. Flynn — ADDRESS 402 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--6-9-19—H. P. Co.—1000 Bks.

D.48975 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48975

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 W Brass ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Shipley

(a) RESIDENCE. No. 604 W Brass ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Widow George Shipley

6 DATE OF BIRTH (month, day, and year) Aug. 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Fahy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sallie Gaffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ida E Shoemaker
(Address) 604 W Brass St

15 Filed DEC 15 1920, 19 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to Dec 15, 1920, that I last saw h[illegible] alive on Dec 14/20, 1920, and that death occurred, on the date stated above, at 4 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Wesley Hoag, M. D.

12/14 19 20 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Dec 16 1920
20 UNDERTAKER	ADDRESS
Wm Cook Sons & Nattans	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates

D.48976 HEALTH DEPARTMENT--CITY OF BALTIMORE D.48976

CERTIFICATE OF DEATH 1920

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Bickley & Fallsway ST. Hospital WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Clinton Townshend

(Residence in Baltimore: No. 2832 W. North Ave St.; 39 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)
M	W.	Married

6-DATE OF BIRTH Oct. 18, (Month) (Day), 1881 (Year)

7-AGE	If LESS than 1 day, ... hrs. or ... min.?
39 yrs. 1 mos. 29 ds.	

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Prince George Co

PARENTS

10-NAME OF FATHER: John Townshend

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. Claiu Townshend

(Address) 2832 W. North ave

15

Filed ... 191 Robert P. Harrison,

DEC 15 1920 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec. 15, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1920, to Dec 15, 1920, that I saw him alive on Dec, 14, 1920, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

Unknown (Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Vernon H. Condon M. D.

Dec 15, 1920 (Address) 750 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs. ...	mos. 13	ds.	In the State	yrs. ...	mos. ...	ds.

Where was disease contracted.

If not at place of death?

Former or usual residence 2832 W North Ave

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Dec 17 1920

20-UNDERTAKER: Richard H. Culey — ADDRESS: 2016 Barclay St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

D.48977 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48977

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Kelly ave Nth Washington St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnella Phillips

(Residence in Baltimore: No. Kelly ave Nth Washington St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1839 (Year)

7-AGE, 81 yrs. 4 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. Phillips

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Miranda Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice Phillips

(Address) Kelly Ave

15-

DEC 15 1920

(Signature) Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920, to Dec 14 1920, that I saw h[illegible] alive on Dec 13 1920, and that death occurred, on the date stated above, at 6.30 Am.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Chronic Bright's

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C H Beeler M. D.

12.15, 1920. (Address) Nth Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Johns Church DATE OF BURIAL, Dec 16., 1920

20-UNDERTAKER A S Marshall ADDRESS 3539 Hall Rd

Important. See instructions on back of certificate. Care in preparing this statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48978 ✓ D. 48978

HEALTH DEPARTMENT—CITY OF BALTIMORE

113

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

2-FULL NAME Edward Joseph Benson

(a) RESIDENCE. No. Esopus. New York ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 29 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	abt 27	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ecclesiastical Student

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City N.Y.

PARENTS

10 NAME OF FATHER James Dowes Benson

11 BIRTHPLACE OF FATHER (city or town) Lakewood (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McGrath

13 BIRTHPLACE OF MOTHER (city or town) Lakewood (State or country) Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat ~~Robert P. Harrison,~~

15 Filed DEC 15 1920 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1914, to Dec 15th 1920, that I last saw him alive on Dec 14th 1920, and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis
abt

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Melancholia abt (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Esopus N. Y.

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Dec 13, 1920 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 16 1920
20 UNDERTAKER	ADDRESS
Henry Hauck Son	1301 E Eager St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48979 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48979

CERTIFICATE OF DEATH.

82

1-PLACE OF DEATH Baltimore, Maryland

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2111 St Paul ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia L. S. Cook

(a) RESIDENCE. No. 2111 St Paul St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. A. Cook

6 DATE OF BIRTH (month, day, and year) June 5-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George Schrock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lucretia Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lula Cook (Address) 1534 Linden Ave

15 Filed DEC 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1920, to Dec 15, 1920, that I last saw her alive on Dec 15, 1920, and that death occurred, on the date stated above, at 5. P m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-sclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W H Ingram, M. D.

(Address) 724 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Greenmount — DATE OF BURIAL Dec 18 1920

20 UNDERTAKER Geo W Little — ADDRESS 531 N Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.48980 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48980

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 E. University Place ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Georgianna Showers

(Residence in Baltimore: No. 328 E University Place St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... 6 (Month) ..... 24 (Day), 1841 (Year)

7-AGE, ... 79 yrs. ..... 5 mos. ..... 20 ds.

If LESS than 1 day, ... hrs. or .... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, J. Jobson

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Hetrintage

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Taylor

(Address) 328 E University Place

15- Filed DEC 15 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 12. (Month) ..... 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 1919, to Dec. 14 1920, that I saw her alive on Dec. 14 1920, and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Exhaustion Starvation Apoplexy

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Beetem M. D.

12. 14., 1920 (Address) 20 E Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge Cemetery	Dec. 16., 1920
20-UNDERTAKER	ADDRESS
H E Stughes & Bro	4 & 6 N Broadway

Important. See instructions on back of certificate. Property Classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48981 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48981

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 So. Patapsco ST.: 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Ann Skinner

(a) RESIDENCE. No. 115 So. Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Disney

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Knowles

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Dan. Skinner
(Address)

15 Filed ..... 19.....

C 15 1920 Robert F. Barrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/10 '20, to 12/14 '20.

that I last saw h[illegible]alive on 12/14/20, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D Philip S. Fowler, M. D.

12/15, 19 20 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 17 '20

20 UNDERTAKER N E Hughes ADDRESS 424 N. Broadway

IMPORTANT. Physicians are requested to fill out this certificate of death in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D48982

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 Dover ST.: 22 WARD)

2-FULL NAME Russell Brown

(a) RESIDENCE. No. 732 Dover ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md

PARENTS

10 NAME OF FATHER Geo. W. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hyman Brown

(Address) 732 Dover St.

15 Filed DEC 16 1920 ROBERT P. KRAUSE Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13/1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11th, 1920, to Dec 13th, 1920, that I last saw h— alive on Dec 11th, 1920, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage 4 d

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc about 2 mo

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Fay Bowley, M. D.

12/13/20 19 (Address) 908 S Shore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 16 1920

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Wilkens Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48983 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D48983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Charlottie Sycell.

(Residence in Baltimore: No. Abbottston & Gorsuch ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, June 24, 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Boston Mass.

PARENTS.

10-NAME OF FATHER, Isaac M. Cate.

11-BIRTHPLACE OF FATHER (State or Country), New Hampshire.

12-MAIDEN NAME OF MOTHER Charlotte H. Abbott.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Wagner M.D.

(Address) Woman Hospital

15-~~DEATH~~.

Filed DEC 16 1920, 191... ROBERT P KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 7th 1920, to December 15 1920, that I saw h[er] alive on December 15 1920, and that death occurred, on the date stated above, at 11.25A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension with Arterio sclerosis

121 Operation (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Wm. C. Abbott M. D.

Dec. 15, 1920. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 8 ds. In the State 67 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Abbottston - Gorsuch Ave

Former or usual residence Abbottston - Gorsuch Ave. City

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem — DATE OF BURIAL, 12-17, 1920.

20-UNDERTAKER Henry Gruscin & Sons Co — ADDRESS McCulloh & Orchard Sts

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048984

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048984

CERTIFICATE OF DEATH.

39

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2711 Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A McCleary

(a) RESIDENCE. No. 2711 Jefferson ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Minnie McCleary

6 DATE OF BIRTH (month, day, and year) Mar 24 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work St Cleaning Commission

(b) General nature of industry, business, or establishment in which employed (or employer). 086

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Hagerstown Md
(State or country)

PARENTS

10 NAME OF FATHER John McCleary

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Catherine Ward

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hagerstown Md

14 Informant Mrs. Minnie McCleary
(Address) 2711 Jefferson St

15 Filed DEC 16 1920 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Dec 14 1920, that I last saw him alive on Dec 14 1920, and that death occurred, on the date stated above, at 12 30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm E Stifler, M. D.

12/14 1920 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec. 16th 1920

20 UNDERTAKER E. D. Fanning & Son ADDRESS 1938 E. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 48985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. University Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles McCay

(Residence in Baltimore: No. University Hospital St.; ..... yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), (Day), 1891 (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) "

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lee

(Address) Gaithland Md

15-

Filed DEC 16 1920 ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1920, to Dec. 15 1920, that I saw him alive on Dec. 15 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Ludwig's Angina - Operation Tracheotomy - Pneumonia

..... (Duration) .....yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs. ..... mos. ..... ds.

(Signed) Geo. D. Owens M. D.

Dec. 15, 1920 (Address) Univ. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Jessups, Md.

19-PLACE OF BURIAL OR REMOVAL, Laurel Md

DATE OF BURIAL, Dec. 17th 1920

20-UNDERTAKER Enid Hall

ADDRESS 115 E. West St. Bel Air Md

Important. See instructions on back of certificate.

WATSON

D48986 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 64 D 48986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1201 Warner St. St.: 21 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Watson.

(Residence in Baltimore: No. 1201 Warner St. St.; 2 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married

6-DATE OF BIRTH, July 2nd. 1887, 1
(Month) (Day) (Year)

7-AGE, 33 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. ✓
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Brooklyn, N.Y.

PARENTS.

10-NAME OF FATHER, ------ McCann.

11-BIRTHPLACE OF FATHER (State or Country), New York.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Watson. (husband)

(Address) 1201 Warner St.

15- Filed DEC 16 1920 ROBERT F KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto A. Reinhardt M. D.
(Coroner.)

Dec. 14., 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross A&C	Dec 17 1920
20-UNDERTAKER John F Denny	ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D48987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Pitcher ST.) 14th WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline B. Clarke

(Residence in Baltimore: No. 634 Pitcher St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH. Unknown 1 (Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Wilmington N.C.

PARENTS.

10-NAME OF FATHER, Thomas Savoy

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Susan Gray

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Clark

(Address) 634 Pitcher St

15- DEC 16 1920 ROBERT B KRAUTER

Filed ....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Dec 14 1920, that I saw her alive on Dec 13 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Carcinoma Colon

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Os Uteri

(Duration) yrs. 3 mos. ds.

(Signed) C. A. Finan M. D.

Dec 16, 1920 (Address) 718 S Chas St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Dec 16, 1920

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N. Eutaw St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

248988

HEALTH DEPARTMENT—CITY OF BALTIMORE

248988

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Baby) Mary Brown

(Residence in Baltimore: No. Women's Hospital St.; ....yrs., ...mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Baby

6-DATE OR BIRTH, December 7, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lieut. Comdr. John J. Brown

11-BIRTHPLACE OF FATHER (State or Country), Fall River Massachusettes,

12-MAIDEN NAME OF MOTHER Nonsas Willoby

13-BIRTHPLACE OF MOTHER (State or Country), Easton, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nonsas W. Brown

(Address) #74 County Rd. Annapolis Md.

15- DEC 16 1920 Filed ROBERT E KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7 1920, to Dec. 15, 1920, that I saw her alive on Dec. 15, 1920, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth.
(6½ months pregnancy)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature birth due to hepatic toxemia of mother

(Duration) ....yrs. ....mos. ....ds.

(Signed) K. L. Cable M. D.

Dec. 15, 1920. (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral Cemetery	12/16..., 1920.

20-UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Important. See instructions on back of certificate. Property cleaned. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048989

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048989

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 N Paca St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M Day

(a) RESIDENCE. No. 647 N. Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? 65 yrs. 6 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa A Day

6 DATE OF BIRTH (month, day, and year) May 8, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65 years	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER David Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Jane Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Daniel Eagan
(Address) 916 Penn ave

15 DEC 16 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1920, to Dec 16th, 1920, that I last saw h.. alive on Dec 16th, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Aneurism Rupture
Pressure Symptoms, from a
Subclavian Aneurism

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. B. Evans, M. D.

, 19 (Address) Penn & Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smithville Va	Dec. 6 1920
20 UNDERTAKER Daniel Eagan.	ADDRESS 916 Penn ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048990

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048990

CERTIFICATE OF DEATH

91-08

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Lawman

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bayview Hospital
(Address) Baltimore, Md.

15 DEC 16 1920 ROBERT P. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1920, to Dec. 15, 1920, that I last saw h[illegible] alive on Dec. 15 1920 and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yr. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Fred Smith, M. D.

12/15/1920 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Dec 17 1920

20 UNDERTAKER	ADDRESS
Ehrenwerth & Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

D.48991

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D. 48991

1 PLACE OF DEATH — REGISTERED No. C 79

CITY OF BALTIMORE (No. 206 Hawthorn Road, R. P. St.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John B. Adt

(Residence in Baltimore: No. 206 Hawthorn Road, R. P. St.: 60 yrs. -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: February (Month) 17 (Day), 1835 (Year)

7 AGE: 85 yrs. 9 mos. 27 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: John Adt

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Elizabeth Bauer

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert W. Adt

(Address) Holliday & Pleasant Sts.

15 Robert P. Harrison, M.D., 191 Burial Permit Clerk. REGISTRAR

DEC 16 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 14 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Dec 14 1920, that I saw h[illegible] alive on December 14, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

ca.
(Duration) 2 yrs. ... mos. ... ds

Contributory (SECONDARY) old age

(Duration) ... yrs. ... mos. ... ds.

(Signed) Dr. E. Dactyen M. D.

Dec 15, 1920 (Address) 1702 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: ~~Woodlawn Cemetery~~ — DATE OF BURIAL: 12/17, 1920

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48992 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48992

CERTIFICATE OF DEATH. 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Grimes

(a) RESIDENCE. No. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence

(Address) Preston & Valley Sts.

15 Filed DEC 16 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,

that I last saw h[er] alive on Dec 12, 1920,

and that death occurred, on the date stated above, at 10.10 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Dec 16, 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 17 1920

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48993

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor, St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Noonan

(a) RESIDENCE. No. Preston & Valley, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick Noonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence

(Address) Preston & Valley Sts.

15 DEC 16 1920

Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19..., that I last saw her alive on Dec 12, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Dec 16 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery Long Green Md	Dec 18 1920

20 UNDERTAKER	ADDRESS
K. C. Wiedefeld	914 Greenmt Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48994 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (NO..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Esta Jacobson

(Residence in Baltimore: No. 1418 Eutaw Place St.; ..... yrs., 2 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... November (Month) 2 (Day), 1901 (Year)

7-AGE,	If LESS than 1 day,
19 yrs. 1 mos. 14 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... ~~None~~

9-BIRTHPLACE, (State or Country), Portsmouth, Va.

PARENTS.

10-NAME OF FATHER, Mr. Isaac Jacobson

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mrs Rebecca Karb

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Jacobson

(Address) Portsmouth Va

15-

Filed DEC 16 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December (Month) 16 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1920, to Dec. 16, 1920, that I saw her alive on Dec. 16 1920, and that death occurred, on the date stated above, at 3 10 p. m.

The CAUSE OF DEATH* was as follows:

Round cell sarcoma, occipital region

..... (Duration) yrs. 10 mos. 1 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) yrs. mos. ds.

(Signed) Robert E. Frame M. D.

Dec. 16, 1920 (Address) Howard A. Kelly Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 1 ds. In the State yrs. 2 mos. 1 ds.

Where was disease contracted, if not at place of death? Portsmouth Va

Former or usual residence Portsmouth Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Portsmouth Va	12 16 1920
20-UNDERTAKER	**ADDRESS**
Jack Lewis	1411 E Balto St

Important. See instructions on back of certificate. ... properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48995 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48995

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Carmody

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed DEC 16 1920, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 10 1919, to December 15, 1920, that I last saw her alive on December 14, 1920, and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Sputum exam.

(Signed) P. B. Herman, M. D.

12-15-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenwood Cem. Laurel Md	19
20 UNDERTAKER	ADDRESS
M. G. Flynn	1423 Light St

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

C. Affidavit attached

D. 48996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48996

CERTIFICATE OF DEATH.

X 37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hospital ST.: 11 WARD)

2-FULL NAME Wm. H. Norris.

(a) RESIDENCE. No. Berkley, Md. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? Life yrs. mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Norris

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63 yrs	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Albert Norris

(Address) Darlington Md

15 Filed 12/27/1920 Robert P. Harrison, Registrar

DEC 16 1920 Geo. H. Greene
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-9-, 1920, to 12-16, 1920, that I last saw him alive on 12-16, 1920 and that death occurred, on the date stated above, at 8:5 a. m.

The CAUSE OF DEATH* was as follows:

Lustic Amerypsa

(duration) X yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumania

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory - Clinical findings

(Signed) R. H. Richardson, M. D.

, 19 (Address) Md. Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Palmmarti Harford Co Md	Dec 19, 1920
20 UNDERTAKER	ADDRESS
H. S. Bailey	Darlington Md

TRICATE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exact [illegible] of OCCUPATION is very important. See instructions on back of certificates.

To whom it may concern,

JAN 27 1921

Jan 27-1921

Mr. Wm. H. Norris, patient at the Maryland General Hospital, admitted Dec. 9. 1920, expired Dec. 16. 1920, gave his age at (58) fifty-eight years.

R. W. Richardson M. D.
Md. General Hosp.

Attending internist.

Personally appeared before me, a notary public of the ~~State~~ of Md, in and for the city of Baltimore ~~and made~~ R W. Richardson M.D. and made affidavit in due form to the foregoing facts.

JAN 27 1921

Leah P Birckhead
notary Public

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48997 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48997

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 W Biddle ST.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Moore

(a) RESIDENCE. No. 517 W. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE: Years 61 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Matron (Address) 517 W Biddle St

15 Filed DEC 16 1920 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25th 1920, to Dec 10th 1920, that I last saw her alive on December 10th 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic disease of the arteries with Cerebral Hemorrhages, the first Hemorrhage with Hemiplegia a year or more before I saw her. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) A new cerebral Hemorrhage occurring Dec 10th (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis with Hemiplegia

(Signed) A. K. Bond, M. D.

. 19 (Address) 3104 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: Dec 17 1920

20 UNDERTAKER: Chas. E. Franck ADDRESS: 802 Madison Ave

DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48998 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH A. D. Sutro Sanitarium REGISTERED No. C 29

CITY OF BALTIMORE: (No. Normandy Cathedral Mt. ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George R. Dennis

(Residence in Baltimore: No. A. D. Sutro Sanitarium St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 3 (Day), 1859 (Year)

7-AGE, 61 yrs. 3 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) 660

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. R. Dennis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Johnston

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 2 E. Lexington St

15-

Filed DEC 16 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 15th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 15th 1920, that I saw him alive on Dec 15th 1920, and that death occurred, on the date stated above, at 10 55 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

7 Hrs (Duration) yrs. mos. ds.

CONTRIBUTORY Valvular Heart Trouble

(Secondary) Instant (Duration) Yrs. mos. ds.

(Signed) Stuart B. Kolb M. D.

Dec 16 1920. (Address) 1203 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Princess Anne Md

DATE OF BURIAL, Dec 17, 1920

20-UNDERTAKER Chas. E. Franck

ADDRESS 801 Madison Ave

Important. See instructions on back of certificate. ... should state ... of OCCUPATION is very ... be properly classified. Exact statement ... as that it may be ...

D.48999

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.48999

CERTIFICATE OF DEATH

81

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 114 S. Fulton Ave ST. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Mary Jordi

(Residence in Baltimore: No. 114 S. Fulton Ave. St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: March (Month) 5 (Day), 1843 (Year)

7 AGE: 77 yrs. 9 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Alexander Zimmerman

11 BIRTHPLACE OF FATHER (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Rebecca Keller

13 BIRTHPLACE OF MOTHER (State or country): Balto Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lotta Barkman

(Address) 114 S. Fulton Ave

15 Filed DEC 16 1920, 191

Robert P. Harrison,
REGISTRAR
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 13 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Dec 13 1920, that I saw h er alive on Dec 13, 1920, and that death occurred, on the date stated above, at 12½ m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) Henry L. Alyea M. D.

Dec 16, 1920 (Address) 3640 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudan Park — DATE OF BURIAL: Dec 17, 1920

20 UNDERTAKER: A. S. Marshall — ADDRESS: 3539 Full Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Progressive Cerebral Arteriosclerosis
Pulmonary Oedema

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D 49000 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josh Hospital ST.; 17 WARD) REGISTERED No. C 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elzobeth Daniels

(Residence in Baltimore: No. 540 S Mary St, St. 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem'l	Col.	Single

6-DATE OF BIRTH. ....., 1901
(Month) (Day) (Year)

7-AGE. 18 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... 041

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Fletcher Daniels

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Sanyson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Sanyson

(Address) 590 st Mary st

15- Filed DEC 16 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns Accedte Clothes caught fire from stove (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 17, 1920
20-UNDERTAKER Brown & Ecker	ADDRESS 14 & Schroder

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. properly classified. Exact statement of OCCUPATION is very carefully supplied. AGE

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49001 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49001

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 McElderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Stepney

(a) RESIDENCE. No. 2209 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Stepney

6 DATE OF BIRTH (month, day, and year) don't know 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57 years	unknown	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER Matilda watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Martin. Stepney (Address) 2209 McElderry St

15 Filed DEC 16 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1920, to Dec. 14, 1920, that I last saw her alive on Dec. 14, 1920, and that death occurred, on the date stated above, at 10:35 p.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

(Address) 1532 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dolphin Cemetery	Dec. 18. 1920
20 UNDERTAKER	ADDRESS
Milton Dare	413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49002 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49002

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N Durham ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Brown

(Residence in Baltimore: No. 229 N Durham St.; ..... yrs., 14 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Nov. 3 ~~Dec~~ 14, 1918
(Month) (Day) (Year)

7-AGE, 1 yrs. ~~11~~ 1 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ernest Brown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lillian Champs

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Brown

(Address) 229 N. Durham St

15-

DEC 16 1920 Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 15 1920, that I saw him alive on Dec 17 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

1. Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Adolph C. Eisenhart M. D.

Dec 15, 1920 (Address) 2201 Orleans St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Hill Cemetery	Dec 17, 1920
20-UNDERTAKER	ADDRESS
Milton Davis	1318 Eden St

Important. See instructions on back of certificate. ... should state ... of OCCUPATION is very ... may be properly classified. Exact statement ...

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49003

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3518 Mt. Pleasant Ave ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Callender.

(a) RESIDENCE. NO. 3518 Mt. Pleasant Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Callender.

6 DATE OF BIRTH (month, day, and year) Aug. 26-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Callender (Address) 3518 Mt. Pleasant Ave.

15 Filed DEC 16 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Feby 15, 1920, to Dec 14, 1920, that I last saw her alive on Dec 13, 1920, and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edel V. Athey, M. D.

, 19 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec. 17 1920
20 UNDERTAKER	ADDRESS
Lilly and Zeiler.	403 S. Broadway

D.49004 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49004

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1828 E Monument St. WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie C Pofel

(Residence in Baltimore: No. 1828 E Monument St.; yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, May 17, 1882
(Month) (Day) (Year)

7-AGE, 38 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles W. Miller

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Annie E. Remley

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Pickler

(Address) 2411 Barclay St

15- Dec 16, 191.....
(Registrar.)

Robert P. Harrison,
Burial Permit Clerk.

DEC 16 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) yrs. mos. ds.

(Signed) Wm Enders M. D.
(Coroner.)

12-16 1920 (Address) 4 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec 18, 1920
20-UNDERTAKER	ADDRESS
William Cook	502 E Mathew

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

144782
D49005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49005

CERTIFICATE OF DEATH.

6 18

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6a WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Jones

(a) RESIDENCE. NO. 166 N Lakewood Ave ST., Baltimore Md. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 - 20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5 1/2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Pauline Turner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 DEC 17 1920 ROBERT B ... Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1920, to Dec 15, 1920, that I last saw her alive on Dec 15, 1920, and that death occurred, on the date stated above, at 10.35 p. m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) 1 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Dec 17 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1120 Reed St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049006

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049006

CERTIFICATE OF DEATH.

146

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Dietrick

(a) RESIDENCE. No. 718 S. Rose ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 10 - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Betzellberger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christiana Bohner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Theresa Dietrick
(Address) 718 S. Rose St.

15 Filed DEC 17 1920 16 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/15/ 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Dec 15, 1920,

that I last saw her alive on Dec 15, 1920,

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Abcess of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mastoiditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical symptoms & Autopsy

(Signed) Chas. A' Donnan, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Dec 18 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D49007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49007

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Brenner ST.; 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Wiley

(Residence in Baltimore: No. 1101 Brenner St.; 43 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	col	Mdow

6-DATE OF BIRTH, June (Month) 17 (Day), 1873 (Year)

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Homemak
(b) General nature of industry, business, or establishment in which employed (or employer): HW

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Diggs Wiley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 1101 Brenner

15- Filed DEC 17 1920 191.... ROBERT B KRAUTER STATE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1920, to Dec 14 1920, that I saw h[er] alive on Dec 13 1920, and that death occurred, on the date stated above, at 3.15A m.

The CAUSE OF DEATH* was as follows:

Pneumonia HW

(Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Daniel E. Wagner M. D.

Dec 17, 1920 (Address) 1101 Brenner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cem	Dec 19, 1920
20-UNDERTAKER Daniel Easton	ADDRESS 1101 Brenner

Important. See instructions on back of certificate. ... may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049008 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049008

CERTIFICATE OF DEATH. 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Scott ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dora Mehring

(a) RESIDENCE. NO. 1116 Scott ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Philip L. Mehring

6 DATE OF BIRTH (month, day, and year) June 11 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 15 yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wedmar

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bumany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Sophia Mary Mehring
(Address) 1116 Scott St

15 Filed DEC 17 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 15, 1920, that I last saw h[illegible] alive on Dec 14, 1920, and that death occurred, on the date stated above, at 730 P m.

The CAUSE OF DEATH* was as follows: over

Acute Cardiac dilatation

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J M Lumpkin, M. D.

Dec 17 1920 (Address) 4264 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violets Md	Dec 18 1920
20 UNDERTAKER	ADDRESS
Gus Kobus & Son	2503 E Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—S-24-14—M. & T.—2000 Bks.

Dr Richman 1516 Madison Ave

D49009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49009

CERTIFICATE OF DEATH.

6 120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 E. Baltimore ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Latinsky

(Residence in Baltimore: No. 2138 E Baltimore St.; 25 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) ..... (Day), 1863 (Year)

7-AGE: 57 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 1411 E. Balto

15- Filed DEC 17 1920, 191.....

ROBERT B KRAUTER
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 17 1920, that I saw him alive on Dec 16 191, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Uraemia Chronic Nephritis

Arterio Sclerosis

Myocarditis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Dilatation of Heart

Oedema of Lungs

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Joseph D Glickman M. D.

Dec 17, 1920 (Address) 1516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Nat. Cemet. DATE OF BURIAL, Dec 17, 1920

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

NOTICE.—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D49010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Wehren aged Home — 120 — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 115 Ais Guith St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pincus Pallunsky

(Residence in Baltimore: No. 115 Ais Guith St.; 13 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown, 1 ..... (Month) (Day) (Year)

7-AGE, 76 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balt St

15- Filed DEC 17 1920, 191.... ROBERT E ERLUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 16, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12 1920, to Dec 16 1920, that I saw him alive on Dec 16 1920, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. ... mos. ... ds.

(Signed) M J Baughman M. D.

12/16, 1920. (Address) 1230 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 6 mos. ds. In the State 13 yrs. mos. ds.

Where was disease contracted, if not at place of death? 511 S. Pulaski St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Washington Road	Dec 17, 191..
20-UNDERTAKER	ADDRESS
Jos Lenk,	1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049011 HEALTH DEPARTMENT—CITY OF BALTIMORE 049011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St.: 6 Ward)

REGISTERED No. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Yent

(a) RESIDENCE. No. 2037 E. Jefferson St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~48~~	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Charles Yent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records, (Address) New City Hospital

15 DEC 17 1920 ROBERT A KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from December 15 1920 to December 15 1920.

that I last saw him alive on December 15 1920.

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B Bateman M. D.

12/15/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Dec 18 1920
20 UNDERTAKER P Fleming	ADDRESS 2016 Orleans

CAUSE OF DEATH should be stated EXACTLY. Every item of information should be accurately supplied. AGE should be stated at last birthday. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049012

HEALTH DEPARTMENT—CITY OF BALTIMORE

049012

CERTIFICATE OF DEATH.

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Highland St. No 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie B. Norton

(a) RESIDENCE. No. 417 S. Third ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or, WIFE of): Wm. H. Norton

6 DATE OF BIRTH (month, day, and year): Oct. 27th 1860

7 AGE — Years: 60 — Months: 1 — Days: 17 — If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Cyrus W. Nixon
(Address): 417 S. Third St.

15 Filed DEC 17 1920, 19 ROBERT J. BRAUER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 14th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1st, 19 20, to Dec 14, 19 20,

that I last saw h[er] alive on Dec 10, 19 20,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Interstitial Interstitial Nephritis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr., M. D.

12/16, 19 20 (Address) N 38 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec 18th 1920
20 UNDERTAKER	ADDRESS
Philip Herring	Orleans St. 2016

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of cause of DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49013 ✓ 32 D49013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 E. Gay ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wenner

(a) RESIDENCE. No. 1805 E. Gay, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Wenner

6 DATE OF BIRTH (month, day, and year): July 11 1857

7 AGE — Years: 63 Months: Days: 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Witte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Kuntz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas Wenner
(Address) 1805 E. Gay

15 FILED DEC 17 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1920, to Dec 14 1920, that I last saw h. alive on Dec 14 1920, and that death occurred, on the date stated above, at 4 P. a.m.

The CAUSE OF DEATH* was as follows:

c Stomach

Duodenum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gall Stones

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. L. Dodweell M. D.

19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 17 1920
20 UNDERTAKER	ADDRESS
John Kerwig & Co	2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should STATE EXACTLY.

D 49014 rear of 13th near Gough St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. rear of 13th ..... St.: 26 Ward)

REGISTERED No. C 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nick John

(Residence in Baltimore: No. 335 E 13th St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on, back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know ....., 1 .....
(Month) (Day) (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Greece

PARENTAGE

10-NAME OF FATHER, Nicholaus

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna P. Johns

(Address) 335 E 13th St

15- DEC 17 1920 ROBERT P. KRAUTER

Filed ....., 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)
Medicate ..... and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto S. Rudolph M. D.
(Coroner)

12/16, 1920 (Address) 15-040 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, Dec 17, 1920

20-UNDERTAKER John Herring & Co

ADDRESS 2008 Orleans

Homicide by ax

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49015

CERTIFICATE OF DEATH.

REGISTERED NO. 1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3806 Mt. Pleasant ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rachael Bayer

(a) RESIDENCE. NO. 3806 Mt Pleasant ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Bayer

6 DATE OF BIRTH (month, day, and year) May 7 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany Bavaria

PARENTS

10 NAME OF FATHER Valentine Zimmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Dorothea Hetzinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria Germany

14 Informant Mrs Rachael Bayer (Address) 3806 Mt Pleasant

15 Filed DEC 17 1920 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1918, to Dec 15, 1920, that I last saw h alive on Dec 15, 1920, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows: OVER

Cardiac Dilatation
Pernicious Congestion of Lungs abt 1 yr
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
abt 3 or 4
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kaufmann M. D.

12/16 1920 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Dec 18 1920
20 UNDERTAKER	ADDRESS
John Herring & Co	2011 Eastern

MAKE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. myocarditis.
No cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49016 HEALTH DEPARTMENT—CITY OF BALTIMORE D49016

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S Linwood St. Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Waclawski

(a) RESIDENCE. No. 618 S Linwood St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9 1919

7 AGE — Years: 1 — Months: — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Waclawski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Kamela Sosnicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Joseph Waclawski.

(Address) 618 S. Linwood Ave

15 Filed DEC 17 1920 ROBERT B. L... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1-20, 19.., to Dec-16, 19 20, that I last saw h... alive on Dec 15 20, and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Gallis Colletus

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rysamek, M. D.

(Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Dec 18 1920

20 UNDERTAKER: M. F. Sadowski, ADDRESS: 905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49017

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Light St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Watkins

(a) RESIDENCE. No. 1409 Light St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 y. s. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) Shirt Maker

(c) Name of employer North Bros

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robb Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Adaline Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs M. Grice
(Address) 1409 Light St

15 DEC 17 1920 ROBERT B. LATIMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 14, 1920, to Dec 14, 1920,

that I last saw ~~her~~ alive on Dec 14, 1920,

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Wm E Stifler, M. D.

12/15 1920 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 17 1920
20 UNDERTAKER	ADDRESS
E. J. Banning	1460 Battery Ave

INSTRUCTIONS—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049018

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049018

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1100 Forest St ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosemary Justina Buckley

(a) RESIDENCE. No. 1100 Forest Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9 1920

7 AGE: Years | Months | Days: 8 days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos R. Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Minni Mathiesen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant (Address)

15 Filed DEC 17 1920 19 ROBERT A. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 16, 1920, that I last saw her alive on Dec 16, 1920, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows;

(Hereditary) T.B.

(Sanitorium)

(duration) yrs. mos. 8 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Simmons, M. D.

, 19 (Address) 1803 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Patrick Cem	12/17/20
20 UNDERTAKER	ADDRESS
Mr & Mrs H & Funk	1838 N Paca

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Missing

#D 49019

Spec.—8-24-14—M. & T.—2000 Blks.

D 49020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Carrisle St.; 19 WARD) REGISTERED NO. C 1979

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ellen Myers

(Residence in Baltimore: No. 410 S. Carrisle St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. July (Month) 11 (Day) 1857 (Year)

7-AGE. 63 yrs. 5 mos. 4 ds.

If less than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER. Enoch Zuck

11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chester D. Myers

(Address) 410 S. Carrisle St

15- Filed DEC 17 1920 191 ROBERT B. KRAUTER Registrar.

N.B.—Every item of information must be given if possible. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2nd 1920, to Dec. 15th 1920, that I saw her alive on Dec. 15th 1920, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of the Heart

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Probably 8 or 10 weeks (Duration) yrs. mos. ds.

(Signed) C. L. Nichols M. D.

Dec. 16, 1920 (Address) 130 S. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Oxford Pa. DATE OF BURIAL, Dec. 18, 1920

20-UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lond

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49021 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D49021

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 Brunswick ST.; 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes C. Steinacker

(a) RESIDENCE. No. 453 Brunswick ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Steinacker

6 DATE OF BIRTH (month, day, and year) Nov 20-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Toomey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant L. T. Steinacker

(Address) 453 Brunswick St

15 Filed DEC 17 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Dec 15, 1920; that I last saw her alive on Dec 14, 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Neph Colitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. findings

(Signed) H. A. Tuell, M. D.

12/17, 1920 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/18 1920

20 UNDERTAKER George W Jahn Fallon & Fayette ADDRESS

N. B. WHILE each question should be carefully answered so that it may be properly recorded, the information should be carefully supplied in the case of the CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

049022 HEALTH DEPARTMENT—CITY OF BALTIMORE V 049022

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Jenkins alley St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola White

(Residence in Baltimore: No. 1122 Jenkins alley St.; 0 yrs. 5 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 22nd (Day), 1920. (Year)

7-AGE, 0 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. (or) ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER, James White

11-BIRTHPLACE OF FATHER (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER Burnice Pulley

13-BIRTHPLACE OF MOTHER (State or Country). Anne Arundel Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Cynthia Pulley

(Address) 1122 Jenkins alley

15-

Filed DEC 17 1920, 191.... ROBERT B KRAUTER

Burial Permit Issued

N.B.—Every item of information called for in this CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 14 1920, to December 15 1920, that I saw h[illegible] alive on December 15 1920, and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows: Obs

Abcess & Diarrhea last

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) ....

..... (Duration) ....yrs. ....mos. 5 ds.

(Signed) W W Caudell M. D.

Dec 15, 1920. (Address) 1369 N Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Arnold Sta Md

DATE OF BURIAL, Dec 18, 1920

20-UNDERTAKER Mrs Robt A Elliott

ADDRESS 725 Ashland ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49023 HEALTH DEPARTMENT—CITY OF BALTIMORE D49023

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1142 N. Payson ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Carroll Lloyd. Jr.

(a) RESIDENCE. No. 1142 N. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 15-1920

7 AGE	Years	Months	Days	If LESS than 1 day, 24 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Carroll Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Camilla Clay Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew Carroll Lloyd.

(Address) 1142 N. Paysonst

15 Filed DEC 17 1920 ROBERT B KRAUTER Registrar

Burial Permit Given

N. B.—WRITE PLAINLY. WITH [illegible] mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 16, 1920, that I last saw him alive on Dec 16-, 1920, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

"Premature Birth"

Congenital debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Estelle Hemmig, M. D.

12/16 1920 Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec 17 1920
20 UNDERTAKER	ADDRESS
H B Hyppert	2316 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

049024 HEALTH DEPARTMENT—CITY OF BALTIMORE 049024

CERTIFICATE OF DEATH.

REGISTERED NO. C 108

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2138 Brunt ST. 14 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Lucinda Earle
(Residence in Baltimore: No. 2138 Brunt St. 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, Colored
5-~~SINGLE~~ MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married
6-DATE OF BIRTH, January 17, 1880 (Month) (Day) (Year)
7-AGE, 40 yrs. 10 mos. 17 ds.
If LESS than 1 day, ...hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Domestic
9-BIRTHPLACE, (State or Country) Maryland.

PARENTS.
10-NAME OF FATHER, Edward W. Patterson
11-BIRTHPLACE OF FATHER (State or Country). Maryland.
12-MAIDEN NAME OF MOTHER Janine Spriddle
13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James E. Patterson
(Address) 2138 Brunt St.

15- Filed DEC 17 1920 191 ROBERT B KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920, to Dec 15 1920, that I saw her alive on Dec 14 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Ruptured Appendicular abscess

(Duration) yrs. mos. 5 ds.

(Signed) Charles C. Clarke M. D.

Dec 17, 1920 (Address) 1306 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? W
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon
DATE OF BURIAL, Dec. 19, 1920
20-UNDERTAKER P. B. Dye & Son
ADDRESS 102 Ellwood Ave

N. B.—Every item of information should be clearly written, so that it may be properly copied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Hayden

D49025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 507 McMechen ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Hayden

(Residence in Baltimore: No. 507 McMechen St.; Aft 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)

7-AGE. 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 83

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Hayden

(Address) 507 W. McMechen St

15- Filed DEC 17 1920, 191.. ROBERT B KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15th 1920, to Dec. 15th 1920, that I saw h[illegible] alive on Dec. 15th 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

Dec 16, 1920. (Address) 924 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Zion — DATE OF BURIAL, Dec 18, 1920

20-UNDERTAKER John H. Owens — ADDRESS 538 Dolphin St

N. B.—Every item of information should be carefully written. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Progressive hemiplegia not apoplectic. No terminal hemorrhage.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D.49026 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49026

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1069 W Lexington ST. 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loyd T. Wells

(Residence in Baltimore: No. 1069 W Lexington St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	married

6-DATE OF BIRTH, May (Month) 14 (Day), 1875 (Year)

7-AGE, 66 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home Infirmary

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel Wells

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wells

(Address) 1064 W Lexington St

15- Filed DEC 17 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Hemorrhage Lung
week
(Duration) about 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart from over Exertion (Duration) yrs. mos. ds.

(Signed) James W Preston M. D.
(Coroner.)
Dec 15, 1920 (Address) 20 N Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Dec 18, 1920
20-UNDERTAKER	ADDRESS
Geo H Holland	1631 Pennsylvania Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.49027 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49027

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 McCulloh ST. 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Pease

(Residence in Baltimore: No. 1732 McCulloh St.; 1 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Infant

6-DATE OF BIRTH, Mar 20, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Pease

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Lettie Chandler

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lettie Pease

(Address) 1732 McCulloh

15-

Filed ....., 191.... Robert P. Harrison Registrar.

DEC 17 1920

Burial Permit Clerk

N.B.—Every item of information must be given if possible. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1920, to Dec 16 1920, that I saw h[illegible] alive on Dec 16 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

A. E. Gastro Enteritis

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Measles Influenza

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Earl Short M. D.

Dec 17, 1920 (Address) 1617 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 17, 1920

20-UNDERTAKER	ADDRESS
James H Dennis	1303 Presstman St

Spec.—5-19-13—M. & T.—500 Bks.

0.49028 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49028

CERTIFICATE OF DEATH. 151 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Maryland Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 4½ Mo Infant

(Residence in Baltimore: No. 401 Maryland Ave. St.; —yrs., —mos., —ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, December (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs....mos. ✓ ds. If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, E. Clyde Miller

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Lillie B Hoffmann

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Hoffman

(Address) 405 Maryland Ave

15- Filed DEC 17 1920, 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH must be stated in plain terms, so that it may be understood. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1920, to Dec 15 1920, that I saw her alive on Dec 15 1920, and that death occurred, on the date stated above, at 1250 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....

.....

.....

.....(Duration)....yrs....mos....da.

CONTRIBUTORY (Secondary) .....

.....(Duration)....yrs....mos....da.

(Signed) H. W. Bond M. D.

Dec 16..., 1920 (Address) 521 Shawan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? Place of death

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

DEC 1 1920
Department of Health

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49029 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49029

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Simms

(a) RESIDENCE. No. 910 Warner ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 13 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Simms

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Jane Owens

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant
(Address) Robert P. Harrison,

15 Filed DEC 17 1920 19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 15, 1920, that I last saw him alive on Dec 15, 1920, and that death occurred, on the date stated above, at 12¼ p m.

The CAUSE OF DEATH* was as follows:

Prematurity
(30 mks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Warren Reece, M. D.

12-15, 1920 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health,	ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

383

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49030 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49030

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Simms

(a) RESIDENCE. No. 910 Warner ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day 13 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER William Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Jane Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Robert P. Harrison,

15 Filed DEC 17 1920, 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 15, 1920, that I last saw him alive on Dec 15, 1920, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Prematurity
(30 wks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

12-15, 1920 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

N. B.—Whole information should be carefully supplied, so that it may be prepared CAUSE OF DEATH in plain terms, so that it may be prepared TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49031 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49031

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N Curley St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen B Fleissner

(a) RESIDENCE. No. 724 N Curley St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Fleissner

6 DATE OF BIRTH (month, day, and year) Sept 8 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sanitary Burner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Leonard Fleissner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Josephine Wojciechowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Leonard Fleissner

(Address) 223 S Patterson park ave

15 Filed DEC 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 15, 1920, that I last saw h— alive on Dec 15, 1920, and that death occurred, on the date stated above, at 9 25 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary D. B

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Lowe, M. D.

Dec 17, 1920 (Address) 1801 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Dec 18 1920

20 UNDERTAKER Wendell D Nagel & Son

ADDRESS 37 [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49032 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.49032

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Balto Md. REGISTERED NO.

CITY OF BALTIMORE: (No. 1025 Wilcox Av ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Bell Barry

(a) RESIDENCE. No. 1025 Wilcox ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ William Barry

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph E Hallar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Sweeny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Charles Hallar

(Address) St Helena Md.

15 Filed DEC 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 1920, to Decemb 15 1920, that I last saw h alive on Decemb 15 1920 and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? 1025 Wilcox

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos F Stevens, M. D.

Dec 15 1920 (Address) 2866 Lafayette Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Dec. 18 19
20 UNDERTAKER Lilly & Fuhr,	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D. 49033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49033

CERTIFICATE OF DEATH.

39

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 937 N Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs A. E. Smith.

(a) RESIDENCE. NO. 937 N Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) M. E. Smith

6 DATE OF BIRTH (month, day, and year) .....

7 AGE: Years 54 Months 5 Days 3 If LESS than 1 day, hrs. ..... or ..... min.

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: Photographer.

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: A. E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: E. J. Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gaddis Md

PARENTS

14 Informant: Charles A. Smith

(Address) 937 N. Broadway

15 Dec 17 1920 Robert P. Harrison Registrar

(Burial Permit Clerk)

DEC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/20.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1920. to Dec 14 1920.

that I last saw him alive on Dec 14 1920.

and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue. 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion 2 d.

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Microscopic Section

(Signed) E. B. Gladden M. D.

, 19 (Address) 1436 Bonney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Dec 18 1920

20 UNDERTAKER: William G. Schaeffer

ADDRESS: 1816 Monument

mation should be given in plain terms, so that it may be understood. See that CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49034 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49034

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmet Johnson

(a) RESIDENCE. No. 3933 Roland ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Jessie Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tabor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Johnson

(Address) ~~3933 Roland Ave~~

15 Filed DEC 17 1920

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1920, to Dec. 17, 1920, that I last saw h.~~e~~ alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Solon D. Rodgers, M. D.

12/17 1920 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Dec 20 1920
20 UNDERTAKER	ADDRESS
Chesworth & Son	Chestnut

mation should be given. CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 49035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49035

CERTIFICATE OF DEATH.

X 64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gunning Sanitarium Attd. St.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Virginia A. Macon

(Residence in Baltimore: No. Charlottesville Va St.; ..... yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, December 16, 1920
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, George W. Sims

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Francis Meredith

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. A. J. Gunning

(Address) Attd. Fremont Rd

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

DEC 17 1920 Burial Permit Clerk

N.B.—Every item of information should be given as accurately as possible, so that it may be of use in preparing CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1920, to Dec 16 1920, that I saw h.. alive on Dec 16 1920, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alfred J. Gunning M. D.

Dec 16, 1920 (Address) Attd. Charlottesville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 16 ds. In the State same yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Charlottesville Va

Former or usual residence Charlottesville Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Charlottesville Va	Dec 18, 1920
20-UNDERTAKER	**ADDRESS**
John Cuttitta Sull	120 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49036 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49036

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Riviera Cr ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Lillian Brooks

(a) RESIDENCE. No. 1100 Riviera Cr ST., 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11 "20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lillian Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Brooks
(Address) 1100 Riviera Cr

15 Filed Robert P. Harrison, Registrar

DEC 17 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1920, to Dec 16, 1920, that I last saw h.. alive on Dec 16, 1920, and that death occurred, on the date stated above, at 9 C m.

The CAUSE OF DEATH* was as follows:

Convulsion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mal-nutrition

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Dec 18 1920
20 UNDERTAKER	ADDRESS
Geo J Smith	Fayette

mation known. CAUSE OF DEATH in plain terms, so that a definite and correct classification may be made. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49037 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49037

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.....

CITY OF BALTIMORE: (No. Broadway ST.: (E. or W.) WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Smith

(a) RESIDENCE. No. 4000 Fleetway Road ST.. WARD. Baltimore Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Dashiell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Dashiell 1200 N. Ellwood Ave

15 Filed DEC 17 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Dec 15, 1920, that I last saw her alive on Dec 15, 1920, and that death occurred, on the date stated above, at 2:10 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis
Uremia

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) anemia, due to bleeding from uterus (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Examn of urine

(Signed) Ralph E Sibarts, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	12/18 1920
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	1180 N. Royal Ave

Make CAUSE OF DEATH in plain terms, as directed on back of certificates. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49038 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49038

CERTIFICATE OF DEATH. 81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N. Luzerne ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. McDorman

(a) RESIDENCE. No. 137 N. Luzerne ST., ... WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. McDorman

6 DATE OF BIRTH (month, day, and year) March 18-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home ppo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Risdon Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah A. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Annie Dorman 137 N. Luzerne ave.

15 Filed DEC 17 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Dec 16, 1920, that I last saw h[illegible] alive on 11 15 1920, and that death occurred, on the date stated above, at 4 [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Hardening of Arteries

Ward

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? N/A Date of

Was there an autopsy? N/A

What test confirmed diagnosis? Clinical

(Signed) Celtus Geary M.D.

12/16 1920 (Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Dec 19 1920
20 UNDERTAKER	ADDRESS
Wm. E. Blacke	427 N. Broadway

mation should be given. See instructions on back of certificate.
CAUSE OF DEATH in plain terms. Do not use abbreviations or technical words. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease causing this condition. Be sure to answer each question. If there is no person in attendance, the coroner must certify and report the case. Write plainly with pen and ink and use no abbreviations. The space provided for each answer is sufficient if the answer is brief and to the point. Do not write in margins or between lines. The certificate must be filled out, signed and returned to the Registrar before a burial permit will be issued. The prompt and accurate filing of this certificate is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49039

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49039

CERTIFICATE OF DEATH.

108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St Agnes' Hospital ST.: 70 WARD)

2-FULL NAME Thelma V. Smith

(a) RESIDENCE. NO. 1914 W. Fairmount Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12 yrs.	6 ~~not known~~	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student 000

(b) General nature of industry, business, or establishment in which employed (or employer) St. Martin's Acad'

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Albert C. Smith

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country) ~~Not Known~~

12 MAIDEN NAME OF MOTHER Josephine Mills

13 BIRTHPLACE OF MOTHER (city or town) ~~Not Known~~ (State or country) Baltimore Md

14 Informant Mr. Albert Smith

(Address) 1914 W Fairmount Ave

15 Filed Dec 17, 19 Robert P. Harrison Registrar

DEC 17 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Dec 17, 1920, that I last saw h[illegible] alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis, with localized peritonitis

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of? Dec. 10 & Dec 16

Was there an autopsy? No Laparotomy

What test confirmed diagnosis?

(Signed) Winfield W. Craig M. D.

, 19 (Address) St. Agnes Hosp. R. Z. M.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — New Cathedral — DATE OF BURIAL Dec 20 1920

20 UNDERTAKER Geo W Little ADDRESS 631 N Eutaw

CAUSE OF DEATH ... See instructions on ... TION is very important.

Spec.—6-9-19—H.P. Co.—1000 Bks.

D.49040 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49040

CERTIFICATE OF DEATH.

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Evans Chapel Road 27th WARD)

2-FULL NAME Mary E Elliott

(a) RESIDENCE. No. 32 Evans Chapel Road St. 27th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M Elliott

6 DATE OF BIRTH (month, day, and year) Dec 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C & O 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward H Belcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Ames

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John M Elliott (Address) 32 Evans Chapel Road

15 Filed DEC 17 1920 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Dec 16, 1920, that I last saw her alive on Dec 16, 1920, and that death occurred, on the date stated above, at 8 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Regurgitation
(duration) 1 yrs. 6 mos. ds.+

CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 1 yrs. 6 mos. ds.+

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart sounds, Albumin & casts

(Signed) M. J. Foley, M. D.

12/17 1920 (Address) 422 Pt Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Dec 18 1920

20 UNDERTAKER McCardell & Nattans ADDRESS

mation should be given. CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49041 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49041

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 S. Bouldin ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schaller

(a) RESIDENCE. No. 511 S. Bouldin ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-16-20

7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Schaller

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John Schaller
(Address) 511 S Bouldin St

15 Filed DEC 18 1920, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920 to Dec 16, 1920, that I last saw her alive on Dec 16, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

6 Month Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hydramnios

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A H B Sellow, M. D.

12/16 1920 Address 515 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Embry. Dept

DATE OF BURIAL: 12/17 1920

20 UNDERTAKER

ADDRESS

mation should be given. CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49042

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 S. Bouldin ST. 26 WARD)

2-FULL NAME Minnie Schaller

(a) RESIDENCE. NO. 511 S. Bouldin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-16-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. on 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Schaller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John Schaller (Address) 511 S Bouldin St

15 Filed DEC 18 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Dec 16, 1920, that I last saw her alive on Dec 16, 1920 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

6 Months Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydramnios

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible] M. D

, 19 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Hopkins Embalmed	12/17 1920
20 UNDERTAKER	ADDRESS

mation should be given in plain terms, so that the CAUSE OF DEATH in plain terms, so that the CAUSE OF DEATH is very important. See instructions on back of certificate.

D.49043 HEALTH DEPARTMENT—CITY OF BALTIMORE D49043

CERTIFICATE OF DEATH. REGISTERED NO. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 750 Bradley ST.: 17 WARD)
(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Green St.; yrs., 8 mos. ds.
(Residence in Baltimore: No. 750 Bradley st.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, Aug. (Month) 15 (Day), 1891 (Year)

7-AGE. 29 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.
10-NAME OF FATHER, Needham Green
11-BIRTHPLACE OF FATHER (State or Country), Virginia
12-MAIDEN NAME OF MOTHER Mary Robinson
13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane Robinson
(Address) 1511 N. Fairmount Ave

15- Robert P. Harrison, Filed DEC 18 1920 191 Burial Permit Clerk Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec. (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said us (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
(5 minutes) duration
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY Acute Indigestion
(Secondary)
1 hr (Duration) ....yrs. ....mos.
(Signed) J. S. Hennessy M.
(Coroner.)
Dec. 17, 1920 (Address) 2802 E. Fayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Grants Hill Ct. Westmoreland Co Va. DATE OF BURIAL Dec. 19
20-UNDERTAKER J. L. Brown & Son ADDRESS 1018 W. Mont
Ledstown Wharf, Rappahannock river - Westmoreland co Va

Spec.—8-24-14—M. & T.—2000 Blks.

D.49044 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 15

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Ferguson

(Residence in Baltimore: No. 2606 Chelsea Terrace St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	

6-DATE OF BIRTH, December (Month) 15 (Day), 1920 (Year).

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 5 hrs. or ___ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Allen L. Ferguson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lucretia Shuler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allen Ferguson

(Address) 2606 Chelsea Terrace

15- Filed DEC 18 1920, 191... Robert P. Harrison, Registrar. Burial Permit Clerk.

N.B.—Every item in CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 15 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 15, 1920, that I saw h[illegible] alive on Dec 15, 1920, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Greenberg M. D.

Dec 15, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Louden Park Cemetery — DATE OF BURIAL, Dec 18, 1920.

20-UNDERTAKER H. E. Hughes — ADDRESS 417 N. Broadway

4471-J

...—6-9-19—H. P. Co.—1000 Bks.

D.49045 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49045

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 29 E Monument St. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloster Valenziano

(a) RESIDENCE. NO. 2917 E Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Joseph Valenziano

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rose Florio

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Joseph Valenziano
(Address) 2919 E Monument

Filed ..., 19... Robert P. Harrison, Registrar.

DEC 18 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 17, 1920, that I last saw h... alive on Dec 17, 1920, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY —
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F. J. Newman, M. D.

(Address) 420 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec 18 1920
20 UNDERTAKER	**ADDRESS**
F. A. Krause & Son	703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49046 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49046

(1442)

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura West

(a) RESIDENCE. NO. 862 Rabary St ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. 6 mos. 15 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	34	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None and

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thornton Semans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Se[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant [illegible] Penfold Place [illegible]
(Address)

15 Filed DEC 18 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15- 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 6- 1920. to Dec 15- 1920.

that I last saw her alive on Dec 15- 1920.

and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Streptococcus viridans septicemia with ~~following~~ rheumatic endocarditis

(duration) yrs. 6 mos. ^ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? Blood culture-positive

(Signed) Henry H. Thomas Jr M. D.

(Address) Jul 5th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 18 1920
20 UNDERTAKER	ADDRESS 114 N
Brown & Freeland	Schroder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS mation should be carefully supplied. AGE should be stated EXACTLY. Examine statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49047

CERTIFICATE OF DEATH.

10-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 Esther Pl. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J E White

(a) RESIDENCE. NO. 3211 Esther Place WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Catherine E White

6 DATE OF BIRTH (month, day, and year) March 21 1886

7 AGE: Years 34 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert E White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Nellie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Catherine E White

(Address) 3211 Esther Place

15 Filed DEC 18 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1920 to Dec 17 1920

that I last saw her alive on Dec 17 1920

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Insley M. D.

. 19 (Address) 2438 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral | DATE OF BURIAL Dec 21 1920

20 UNDERTAKER: Wm Cook | ADDRESS 5026 Harford Ave

Wm Insley 2438 Balto

back of certificate. mation should be given in plain terms, so that CAUSE OF DEATH may be clearly understood. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49048 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49048

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 N. Washington ST.; 7 WARD)

2-FULL NAME Annie V. Deer

(a) RESIDENCE. No. 1034 N. Washington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. W. Deer.

6 DATE OF BIRTH (month, day, and year) Unknown 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Benner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant C. W. Deer (Address) 1034 N. Washington st

15 Filed DEC 18 1920 Robert P. Harrison Registrar

[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1920, to December 16, 1920, that I last saw her alive on December 15, 1920, and that death occurred, on the date stated above, at 8.10 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lung

Tuberculosis of Lung.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lung.

(duration) yrs. 5 mos. 10 ds.

18 Where was disease contracted if not at place of death? Rosedale Md.

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) D. J. W. Kennard, M. D.

12-16 1920 Address 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Dec 20 1920
20 UNDERTAKER	ADDRESS
George J. Rutter	735 Harford Ave.

N. B.—Information should be entered in ink, and in plain terms, so that it can be easily read. CAUSE OF DEATH in plain terms, so that it can be easily read. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49049

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 224 N Durham St

CITY OF BALTIMORE: (No. Thelma Jenkins ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Jenkins

(Residence in Baltimore: No. 224 N Durham St.; 34 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, April 10 (Month) (Day), 1886 (Year)

7-AGE, 34 yrs. 8 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, James Brown

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Emma Denby

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Carmack

(Address) 18 S Bethel St.

15-

Filed DEC 18 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N.B.—Every item of information must be given, so that it may be understood in plain terms, so that if any CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Dec 15 1920, that I saw h[er] alive on Dec 15 1920, and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard L Eastwood M. D.

Dec 15, 1920 (Address) 1514 E. Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Cemetery	Dec 19, 1920
20-UNDERTAKER	**ADDRESS**
Miller Davis	413 N Eden St

D.49050 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49050

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Room 134 Ballo. City Court House ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Galloway

(Residence in Baltimore: No. 1529 Eutaw Place St.; 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: August (Month) 11 (Day), 1857 (Year)

7-AGE: 63 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): B&O R.R.

9-BIRTHPLACE, (State or Country): Ballo. Co. Md

PARENTS.

10-NAME OF FATHER: Aquilla Galloway

11-BIRTHPLACE OF FATHER (State or Country): Ballo Co. Md

12-MAIDEN NAME OF MOTHER: Mary E. Kelly

13-BIRTHPLACE OF MOTHER (State or Country): Ballo. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. T. K. Galloway (Brother)

(Address) 318 E. Lanvale St

15-

Filed DEC 18 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N. B.—Every item of information is important, so that it may be entered in plain terms, so that it may be entered in plain terms, so that it may be entered in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49051 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St. 19 WARD) 108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenwood Klemmer Krantz

(a) RESIDENCE. No. 2374 N. Fremont Ave. St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) July 7th, 1916.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Baltimore~~ Md. Balto. Md.

PARENTS

10 NAME OF FATHER Herman Krantz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa. Dauphin County

12 MAIDEN NAME OF MOTHER Floy Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellerson Md.

14 Informant Mother (Address) same address.

15 Filed DEC 18 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1920, to Dec. 16, 1920, that I last saw h[illegible] alive on Dec. 16, 1920, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) R. W. Richardson. M. D.

12/16. 1920 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wood. Cem.	Dec 20 1920
20 UNDERTAKER Jos. L. B. Cook	ADDRESS 1003 N. Gay St

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

pec.—6-9-19—H. P. Co.—1000 Bks.

D.49052 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49052

CERTIFICATE OF DEATH. 109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 E 21st ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Farrior

(a) RESIDENCE. NO. 31 E 21st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Farrior

6 DATE OF BIRTH (month, day, and year) ? ? 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER A. Halyn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Cath Tolar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Egmont Farrior (Address) 31 E 21st St.

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

DEC 18 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13th, 1920, to Dec. 17, 1920, that I last saw h[illegible] alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Obstruction of Bowel

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease Dont Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fecal vomiting

(Signed) Jas M Geraghty, M. D.

, 19 (Address) 1702 St. Charles St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL Dec 18 1920

20 UNDERTAKER E. A. Wiedefeld Jr ADDRESS 501 E 22nd St

CAUSE OF DEATH in plain terms. See instructions on back of CERTIFICATE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49053

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49053

CERTIFICATE OF DEATH.

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 W. 28th St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant (Mohar)

(a) RESIDENCE. No. 501 W. 28th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. 1½ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Dec 16, '20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1 1/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~ NB

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank H. Mohar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dora E. Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Frank H. Mohar

(Address) 501 W. 28th St

15 Filed DEC 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Dec 17, 1920, that I last saw h~~e~~ alive on Dec 17, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Debility, Premature Birth (8 mo)

Foramen Ovale not Closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Fair, M. D.

Dec. 1920 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Freedom Pa	Dec 18 1920
20 UNDERTAKER	ADDRESS
Chenowith Son	Chestnut Ave

CAUSE OF DEATH in plain terms. Information should be obtained from attending physician. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49054 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49054

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3934 Park Heights ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Staiti

(Residence in Baltimore: No. 3934 Park Heights ave St.; ....yrs., 4 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	

6-DATE OF BIRTH, July 27, 1911
(Month) (Day) (Year)

7-AGE, 9 yrs. 6 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Sebastiano Staiti

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Raimondi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sebastiano Staiti

(Address) 3934 Park Heights Ave

15- Filed DEC 18 1920, 191... Robert P. Harrison, Registrar.

Burial Permit Clerk.

N. B.—CAUSE OF DEATH must be given. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16th 1920, to Dec 17 1920, that I saw h... alive on Dec 17 1920, and that death occurred, on the date stated above, at 9 1/2 m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation Dr

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. Testa M. D.

....., 191... (Address) 210 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence New York N. Y.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Dec 20., 1920

20-UNDERTAKER John J Cavan Son ADDRESS 701 Hollins St

Cit 201

20.49055 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49055

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guy Dixon Gaddis

(Residence in Baltimore: No. Lake Shore Ave St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Don't Know 1885. (Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgia A Gaddis

(Address) A A Co Lake Shore

15-

Filed DEC 18 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk

N.B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH must be stated in such terms as will show the disease, and not merely the symptoms of the last illness. Indefinite terms, such as "fever," "debility," "weakness," "cancer," "consumption," "paralysis," "dropsy," "old age," etc., are not sufficient. See instructions on back of certificate. Omissions will cause unnecessary correspondence, and may cause delay in burial. Please write plainly with pen and ink. Use no abbreviations. The space for each item is sufficient for the entry if the information is concise and important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~.) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound in abdomen, fired from pistol in hands of Unknown

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) as above

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. A. Groningh M. D. (Coroner.)

12-18, 1920 (Address) 11 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, West Point Va

DATE OF BURIAL, Dec 18, 1920

20-UNDERTAKER John W Henderson W 1740-R

ADDRESS 1502 E Monument

D49056 HEALTH DEPARTMENT—CITY OF BALTIMORE D49056

CERTIFICATE OF DEATH.

64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1929 E Pratt St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Wemberg

(Residence in Baltimore: No. 1929 E Pratt St.: yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
female	white	Widowed

6-DATE OF BIRTH, unknown (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balt St

15-

Filed DEC 19 1920, 191.. ROBERT E KRAUTER Registrar

Burial Permit Issued

N. B.—Every item of information must be given in plain terms, so that it can be understood. In CAUSE OF DEATH in plain terms, so that it can be understood. In CAUSE OF DEATH in plain terms, so that it can be understood. In CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Bks.

D49057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49057

CERTIFICATE OF DEATH.

50

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tillie Michelson

(Residence in Baltimore: No. 1718 E Balt Street St.; 20 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 64 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levi

(Address) 1711 E Balt St

15- DEC 19 1920 ROBERT E KRAUTER

Filed....., 191... Deputy Registrar. Registrar.

N.B.—Every CAUSE OF DEATH in plain English must be given. Omissions important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28 1920, to Dec. 16 1920, that I saw h.. alive on Dec 16 1920, and that death occurred, on the date stated above, at 11:40 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Chr. Nephritis

Chr. Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 10 ds.

(Signed) B. [illegible] M. D.

Dec. 17, 1920. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 17 ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1718 E Balt St

19-PLACE OF BURIAL OR REMOVAL Hebrew Hebrew Rom DATE OF BURIAL, 12/19 1920

20-UNDERTAKER Jack Levi ADDRESS 1711 E Balt

Dec.—6-9-19—H. P. Co.—1000 Bks.

049058 HEALTH DEPARTMENT—CITY OF BALTIMORE D49058

CERTIFICATE OF DEATH.

REGISTERED NO. 15 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Stein

(a) RESIDENCE. NO. 2328. Reisterstown Road ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lehman Stein

6 DATE OF BIRTH (month, day, and year) Unkn 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Jakon Ryder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Lerinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London

14 Informant Jack Levin (Address) 1411 E Balto St

15 Filed DEC 19 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1920, to Dec. 17, 1920, that I last saw h[illegible] alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 9:05 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + laboratory

(Signed) V. R. Mason, M. D.

17 XII, 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt Hebrew Cem	12/20 1920
20 UNDERTAKER Jack Levin	ADDRESS 1411 E Balto

CAUSE OF DEATH must be filled in plainly. See instructions on back of this TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hughes.

0449059

HEALTH DEPARTMENT—CITY OF BALTIMORE

0449059

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 543 Greenmillion St. 17th WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Hughes

(a) RESIDENCE. No. 543 Greenmillion St. 17th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Abrian

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Salysh Pa

PARENTS

10 NAME OF FATHER: Al Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Amanda Hughes

12 MAIDEN NAME OF MOTHER: Furlong

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Cora Abrian (Mrs. O'Bryan)
(Address) 543 Greenmillion St.

15 DEC 19 1920 EDWIN P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec, 17th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 17th 1920, that I last saw ~~deceased~~ alive on Dec 17th 1920, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis (Indigestion) Heart insufficiency at 2 o'clock in the night

(duration) 2 yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary): Rheumatism

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 543 Greenmillion St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. B. Evans M. D.

, 19 (Address) Bond & Fawkins Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Dec, 19 1920

20 UNDERTAKER: Samuel A. Lindsey

ADDRESS W. Baltimore

mation shown on back of certificate.
CAUSE OF DEATH in plain (Cross, ... TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

049060

HEALTH DEPARTMENT—CITY OF BALTIMORE

049060

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Notre Dame Convent ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Melinda Enders

(Residence in Baltimore: No. Cinquette St ~~and~~ Ashland Ave St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR ~~DIVORCED~~, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... April (Month) 29 (Day), 1840 (Year)

7-AGE,	If LESS than 1 day,
80 yrs. 7 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Convent

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Enders

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Noll

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionedz

(Address) Notre Dame Cinquette St

15- Filed DEC 19 1920, 191... ROBERT J. KLUTER Registrar.

CAUSE OF DEATH. This line must be filled out. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 18 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 17 1920, that I saw her alive on Dec 17 1920, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Hemiplegia

..... (Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) F. J. Kelly M. D.

Dec 18 20, 191... (Address) 110 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Notch Cliff Rd	Dec. 20, 1920
20-UNDERTAKER	ADDRESS
Frank A. Fenk	915 N. Gay St

Spec.—6-9-19—H. P. Co.—1000 Bks.

049061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 2 049061

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3137 Dillon ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella F. Geho.

(a) RESIDENCE. No. 3137 Dillon ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malcolm Geho.

6 DATE OF BIRTH (month, day, and year) Oct. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Patrick Coleman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irelands.

12 MAIDEN NAME OF MOTHER Bridget Scheelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wilbur M. Geho (Son)
(Address) 3137 Dillon St.

15 Filed DEC 19 1920 ROBERT E. LEMMON Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1920, to Dec 16, 1920, that I last saw her alive on Dec 16, 1920, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McAvoy, M. D.

12/17 1920 (Address) 839 S. Ellwood av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Dec 20 1920
20 UNDERTAKER	ADDRESS
Lilly & Zuiler	403 S. Wolfe St.

mation should be given in plain terms, so that it can be understood. In certifying CAUSE OF DEATH in plain terms, so that it can be understood. In certifying CAUSE OF DEATH TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49062 HEALTH DEPARTMENT—CITY OF BALTIMORE D49062

CERTIFICATE OF DEATH. 16 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 W. Carey ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie M. Ward.

(a) RESIDENCE. No. 1315 W. Corey ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

CAUSE OF DEATH IN PAR... TION is very important. See instructions on BACK OF ...

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of B Ward

6 DATE OF BIRTH (month, day, and year) April 11, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife & Domestic Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Landrywork

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Harriett Scodd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Marion Welsh

(Address) 618 Pitcher

15 DEC 19 1920 ROBERT J. BRADEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 17, 1920, that I last saw h.. alive on Dec 17, 1920, and that death occurred, on the date stated above, at 12.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Consolidation

Right Lung, Tuberculer

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1315 W Corey

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

Dec 18, 1920 Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 20 1920
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1364 W Lanvale

Spec.—6-9-19—H. P. Co.—1000 Bks.

049063 HEALTH DEPARTMENT—CITY OF BALTIMORE 049063

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 E. Pratt St. St.: 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sauer

(a) RESIDENCE. No. 1924 E. Pratt St. 2 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. C. Sauer.

6 DATE OF BIRTH (month, day, and year) Jan. 20 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Valentine Waldeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Louisa Kor...

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Geo. C. Sauer. (Address) 1924 E. Pratt St.

15 Filed DEC 19 1920 ROBERT B. ARMUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1920, to Dec. 16, 1920, that I last saw h[er] alive on Dec. 15, 1920, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Eugene L. Pessagno M. D.

Dec. 17. 1920 (Address) 231 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 20 1920.
20 UNDERTAKER: Tilly & Zeile.	ADDRESS: 4031 Wash Ave.

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

2049064

HEALTH DEPARTMENT—CITY OF BALTIMORE

2049064

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 937 S. Third St. ST.: 26 WARD)

2-FULL NAME Mary Anna Schultz

(a) RESIDENCE. No. 937 S. Third St. ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Schultz.

6 DATE OF BIRTH (month, day, and year) July 10 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework, 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Paul Antkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Schultz.
(Address) 937 S. Third St.

15 DEC 19 1920 ROBERT E. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec. 15, 1920, that I last saw h. W alive on Dec. 15, 1920, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Atrophia, Cirrhosis of Liver

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. McConnell M. D.

19 (Address) 633 S. 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 20 1920
20 UNDERTAKER	ADDRESS
Lilly & Zutz	403 S. Broadway

CAUSE OF DEATH ... TION is very important. See instructions on ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049065 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2840 St. Paul ST.: 12 WARD) REGISTERED NO. 29

2-FULL NAME William Galvin

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2840 St Paul ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary Leland

6 DATE OF BIRTH (month, day, and year) Aug 27 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	94	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not employed 087

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Galvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Honorah Conaghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Mary A. Galvin 2840 St Paul St

15 Filed DEC 19 1920 ROBERT I. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to Dec. 17, 1920, that I last saw him alive on Dec. 16, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 10 mos. 23 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Auscultatory Signs Blood Pressure etc

(Signed) Thos. K. Galvin M. D.

19 (Address) 23 E. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 20 1920
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount

CAUSE OF DEATH IN [illegible] TION is very important. See instructions on [illegible]

Dec.—6-9-19—H. P. Co.—1000 Bks.

049066 HEALTH DEPARTMENT—CITY OF BALTIMORE 049066

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cummings

(a) RESIDENCE. No. 1110 E. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18 1920

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James J. Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary T. Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jos. Cummings

(Address) 1110 E. Hoffman St

15 Filed DEC 19 1920 ROBERT E. LAUTER Registrar

Burial Permit 01696

CAUSE OF DEATH to be filled in plainly. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1920 to Dec. 18, 1920, that I last saw him alive on Dec. 18, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature at 8 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis?

(Signed) J. B. Bromwhar, M. D.

12-18 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 20 1920
20 UNDERTAKER	ADDRESS
H. C. Winterfield & Son	Gwynns

...ec.—6-9-19—H. P. Co.—1000 Bks.

949067 HEALTH DEPARTMENT—CITY OF BALTIMORE 949067

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes' Hospital ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Hooper

(a) RESIDENCE. NO. 3503 Emerson St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Hooper

6 DATE OF BIRTH (month, day, and year) June 26 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know (State or country) " " "

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mr. Elmer Hooper

(Address) 2603 Emerson St.

15 Filed Dec 19 1920 ROBERT E. LAZIER Registrar

DEC 19 1920

Burial Permit Clerk

CAUSE OF DEATH. See instructions. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Dec. 17, 1920, that I last saw her alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis - Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic convulsion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory Nos.

(Signed) W. H. Krieg M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec 20 1920
20 UNDERTAKER	ADDRESS
Wm L Miller	2334 Jeffer...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49068 HEALTH DEPARTMENT—CITY OF BALTIMORE D49068

CERTIFICATE OF DEATH. 138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Clairmont St.: 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Myers

(a) RESIDENCE. No. 3409 Clairmont St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Myers

6 DATE OF BIRTH (month, day, and year) 12 3 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schlote

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Amelia Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant August Schlote

(Address) 537 Longwood St

15 Filed DEC 19 1920, 19 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 18 1920

17

I HEREBY CERTIFY, That I attended deceased from 12 16, 1920, to 12 18, 1920, that I last saw h.er alive on 12 18, 1920, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H B Fillow, M. D.

12/19, 1920 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Dec 20 1920
20 UNDERTAKER Peter Nicolaus	ADDRESS 2046 Eastern

mation should be given in these columns. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

[illegible] STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Puerperal

Dec.—6-9-19—H. P. Co.—1000 Blks.

D49069 HEALTH DEPARTMENT—CITY OF BALTIMORE D49069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1724 Reynolds ST.: 24 WARD) 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Betty Oliver

(a) RESIDENCE. No. 1724 Reynolds ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm E. Oliver

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Maggie White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Eng.

14 Informant Mrs Wm Oliver
(Address) 1724 Reynolds

15 Filed DEC 19 1920 19 ROBERT F. FULTON Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1920, to Dec 15, 1920, that I last saw h[illegible] alive on Dec 12, 1920, and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Marasmus

Now

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec 17 1920 (Address) 423 E. Fort Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Dec 20 1920
20 UNDERTAKER Wm Cook	ADDRESS N. Gilmor

CAUSE OF DEATH ... TION is very important. See instructions

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria*; *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....; (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro-Enteritis

Dec.—6-9-19—H. P. Co.—1000 Bks.

1049070 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049070

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 318 N. Paca ST.: 4 WARD)

2-FULL NAME Louis Mc M. Jones.

(a) RESIDENCE. No. 318 N. Paca ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Single~~.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard J. C. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Philomena Mc Mana

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thomas F. Jones (Address) 909 Madison Ave.

15 Filed DEC 19 1920 ROBERT B. REMTER Registrar

Burial Permit Given Sr. O'Mara - 604 Cathedral Street.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1918, to Dec 17, 1920, that I last saw h.. alive on Dec 17, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) "Hemmorrhage Pulmonary" (duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) J O'Mara, M. D.

12/15 1920 (Address) 604 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	12/20- 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

CAUSE OF DEATH ... TION is very important. See instructions on

Dec.—6-9-19—H. P. Co.—1000 Bks.

Sonner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1949071 1949071

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 E Hamburg St. ST.: 24th WARD)

2-FULL NAME Anna. M Sonner

(a) RESIDENCE. NO. 113 E Hamburg. ST., 24th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) August. 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John L Sonner

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Sophie Gouski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) John. L. Sonner 113 E Hamburg St.

15 Filed DEC 19 1920 ROBERT J. BRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Dec 18, 1920, that I last saw h[illegible] alive on Dec 14, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Labor Premature

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Smyak M. D.

. 19 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross AAA	12-19 1920
20 UNDERTAKER	ADDRESS
E. and B Harle	115 E West St

CAUSE OF DEATH to be plainly written. See instructions on back. TION is very important.

pec.—6-9-19—H. P. Co.—1000 Bks.

1049072 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049072

CERTIFICATE OF DEATH. 5 79 REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 109 Aisquith ST., 5 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Goldsmith

(a) RESIDENCE. No. 109 Aisquith ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Fentman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Yankelowitch 215 E. Baltimore St

15 Filed DEC 19 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Dec 18, 1920, that I last saw her alive on Dec 18, 1920, and that death occurred, on the date stated above, at 1 30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) M. D. Taylor M. D.
12 19 20 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale
DATE OF BURIAL Dec 19 1920
20 UNDERTAKER Max Leinsor
ADDRESS 1127 E Balto St

CAUSE OF DEATH must be filled in. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

Piechocki

HEALTH DEPARTMENT—CITY OF BALTIMORE

049073 79 049073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 726 E. Ann ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Piechocki

(Residence in Baltimore: No. 726 E. Ann St.; 36 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Wid'w

6-DATE OF BIRTH, January 21, 1855.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 10 mos. 27 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER Frederick

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jas. J. Sullivan, M.D.

(Address)..... 726 E. Ann St.

15- Filed DEC 19 1920, 191... ROBERT B. KEATLEY Registrar. Burial Permit Given

CAUSE OF DEATH must be stated for every death, no matter how long or short the attendance. Information is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 16 1920, to December 17 1920, that I saw h V alive on December 17 1920, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Own

(Duration)..... yrs..... mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration)..... yrs..... mos. 2 ds.

(Signed) J. J. Sullivan, M. D.

Dec. 19 1920 (Address) 722 E. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	DEC. 20, 1920
20-UNDERTAKER W. F. Sadowski.	ADDRESS, 705 E. Ann St

Spec.—8-24-14—M. & T.—2000 Blks.

049074 HEALTH DEPARTMENT—CITY OF BALTIMORE 28. D49074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 N Carey ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Griffin

(Residence in Baltimore: No. 1116 N Carey St. St. 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 18 (Month) (Day), 1888 (Year)

7-AGE, 32 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Lewis Griffin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Griffin

(Address) 1116 N Carey St

15- Filed DEC 19 1920, 191... ROBERT P KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Dec 18 1920, that I saw h[illegible] alive on Dec 18 1920, and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

A.C. Dilatation of Heart

T. Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary

(Duration) ..... yrs. 16 mos. ..... ds.

(Signed) Edw Ghast M. D.

Dec 19, 1920 (Address) 1812 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Union Chapel Anne Arundel Co Md — DATE OF BURIAL, Dec 21, 1920

20-UNDERTAKER George F. A. Gibson — ADDRESS 513 Fairmount Ave

D49075 HEALTH DEPARTMENT—CITY OF BALTIMORE D49075

175-8

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mer. Gen. Hosp. 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis R. Eanes

(Residence in Baltimore: No. 309 Cathedral St. St.; yrs. 79 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 13, 1841
(Month) (Day) (Year)

7-AGE, 79 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Horse Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 83

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Alexander,

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Frances Stroud

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey Keamodel

(Address) 162 N. North Ave

15- Filed DEC 19 1920. ROBERT B KRAUSER Registrar.

Burial Permit Given

N.B.—Every item of this DEATH in plain terms, so that it may be important. See instructions on back of certificate. CAUSE OF

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said as
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull (5 minutes)

(Street car accident) (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Dec. 18, 1920 (Address) 2802 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. 7 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Howard & Clay Sts.

Former or usual residence 309 Cathedral St.

19-PLACE OF BURIAL OR REMOVAL, Fairview Cem. DATE OF BURIAL, Dec 20, 1920

20-UNDERTAKER George J Smith ADDRESS 1000 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

049076

HEALTH DEPARTMENT—CITY OF BALTIMORE

049076

CERTIFICATE OF DEATH.

91-089

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Appleton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Asteer

(Residence in Baltimore: No. 1829 Appleton St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug. (Month) 27 (Day), 1840 (Year)

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. R. Askew Son

(Address) Brochambeau Apartments Baltimore Md.

15- DEC 19 1920 Filed, 191. ROBERT F. [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 18 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1920, to Dec 18 1920, that I saw h[illegible] alive on Dec 17 1920, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 14 ds.

(Signed) Geo. Bequeaker M. D.

Dec 18, 1920 (Address) 800 Hartman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Dec. 20, 1920

20-UNDERTAKER George J. Smith

ADDRESS 1000 Fayette St

Important. See instructions on back.

49077 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 49077

CERTIFICATE OF DEATH.

X 175.001

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6 Church Home & Infirmary St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob. Sharer

(Residence in Baltimore: No. Government Carroller. Md St.; yrs,, mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, — — ....., 1.....
(Month) (Day) (Year)

7-AGE, 62 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Produce Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 145

9-BIRTHPLACE. (State or Country), Carroll Co. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. R. L. Wink

(Address) Manchester Md.

15- DEC 20 1920 ROBERT F. KRAUSE

Filed ....., 191.. Burial Permit Clerk
Registrar.

N. B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Comp. Com. Fracture
Right Femur

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Clinton Gladis M. D.
(Coroner.)

12/19/20 191... (Address) 245 E. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Government Md	Dec. 21, 192.
20-UNDERTAKER Jacob Winkler & Son	ADDRESS Manchester

Automobile accident

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

Rec.—6-9-19—H. P. Co.—1000 Bks.

049078

HEALTH DEPARTMENT—CITY OF BALTIMORE

049078

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1120 Linden Ave ST. 11 WARD)

2-FULL NAME Infant Walter L. & Marie D. Knell

(a) RESIDENCE. NO. 1120 Linden Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~ or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Dec 18th 1920

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or 5 min.
			5 Min	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter L Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie D Knell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter L Knell

(Address) 1120 Linden Ave

15 Filed DEC 20 1920 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 18. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1920, to Dec 18, 1920, that I last saw h. m. alive on Dec 18th, 1920, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity birth - 7 mos

Conception.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no, Child breathed only a few minutes

What test confirmed diagnosis?

(Signed) J. D. Patterson, M. D.

, 19 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 20 19

20 UNDERTAKER Putnam & Sons ADDRESS 1725 E. Lan Ave

CAUSE OF DEATH must be given. If unknown, state fact and say whether physician was in attendance. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049079

HEALTH DEPARTMENT—CITY OF BALTIMORE

049079

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3025 W. North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Jerome Conway.

(a) RESIDENCE. No. 3025 W. North ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Conway.

6 DATE OF BIRTH (month, day, and year) Aug 4 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	42	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rob. J. J. Conway.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond. Va.

12 MAIDEN NAME OF MOTHER Maria A James.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balti. Md.

14 Informant Lloyd Conway.
(Address) 3025 W. North ave

15 Filed DEC 20 1920 BURKE S. KELLY Registrar

Burial Permit Given

CAUSE OF DEATH to be filled in by physician. See instructions on back of this certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10th 1920, to Dec. 19th 1920, that I last saw him alive on Dec. 19th 1920, and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 22nd 1920

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Jesse C. Nelson, M. D.

, 19 (Address) 3055 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemt. DATE OF BURIAL Dec 21st 20

20 UNDERTAKER Putnam Dyke ADDRESS 1723 N. Lafayette ave

Sec.—6-9-19—H. I. Co.—1000 Bks.

1049080 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1049080

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 318 E Lafayette Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Pierce Kimberly

(a) RESIDENCE. NO. 318 E Lafayette Ave ST.; ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Kimberly

6 DATE OF BIRTH (month, day, and year) June 4 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Kimberly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Bessie Kimberly (Address) 318 E Lafayette Ave

15 Filed DEC 20 1920 ROBERT B. EMMUTES Registrar

Burial Permit Oleet

Dr Tonry 414 E N. Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1920, to Dec 19th, 1920, that I last saw him alive on Dec 18, 1920, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Hemiplegia, Paralysis of Respiratory Centi

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Tonry, M. D.

, 19 (Address) 414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 21 1920
20 UNDERTAKER Wm Cook	ADDRESS 1424 N. Mo.

CAUSE OF DEATH should be given in plain terms. See instructions on back. TION is very important.

1049081

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049081

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Marshall

(Residence in Baltimore: No. 1417 W. Fayette St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH, ... Jan (Month) 7 (Day) ....., 1850 (Year)

7-AGE, 70 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph R. Mann

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Amanda Reiter

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H Beeson

(Address) 6220 Ogontz Ave Phila Pa

15- DEC 20 1920 Filed....., 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Cerebral Hemorrhage

Sudden (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) W. L. Riley (Coroner.) M. D.

Dec 19, 1920 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Dec 20, 1920

20-UNDERTAKER Wm Foos & Sons

ADDRESS E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0449082 42 0449082

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Suburban Ave Waverly (WARD) 9

2-FULL NAME Sarah E. Gribbin

(a) RESIDENCE. No. 3 Suburban Ave Waverly WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Gribbin

6 DATE OF BIRTH (month, day, and year) May 29 1846

7 AGE	Years	Months	Days
	74	7	

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co Md

(State or country)

PARENTS

10 NAME OF FATHER John W Treadwell

11 BIRTHPLACE OF FATHER (city or town) Balto Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Maggell

13 BIRTHPLACE OF MOTHER (city or town) Balto Co Md

(State or country)

14 Informant Thomas Gribbin

(Address) 3 Suburban Ave

15 Filed ..... 19 ..... ROBERT J. KRAMER, Registrar

DEC 20 1920

Bodies for Dissection Must Be Claimed Within 24 Hours

16 Blanche 1504 McCulloh St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to Dec 19, 1920, that I last saw h[illegible] alive on Dec 18, 1920, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of, Sept 28 1920

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Chas. P. Faulkner, M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Dec 22 1920

20 UNDERTAKER Wm Leach 502 E North Ave

ADDRESS Madison 6578

mation and CAUSE OF DEATH in plain terms. CAUSE OF DEATH is very important. See instructions on back of cer

Spec. 6-9-19—H. P. Co.—1000 Blks.

049083

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 049083

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 121 Roland ave ST.) 21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Sanford

(a) RESIDENCE. NO. 121 Roland ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Sanford

6 DATE OF BIRTH (month, day, and year) June 3. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Surveyor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John L. Sanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nash D.C.

12 MAIDEN NAME OF MOTHER Mary H. Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) James L. Sanford 2819 Kennedy ave

15 Filed DEC 20 1920 ROBERT J. FRANZ Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 12. 1920. to Dec 17. 1920.

that I last saw h. alive on Dec 17. 1920.

and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Double

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Senile arteri-sclerosis (duration) ~ yrs. ~ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M. J. Fry, M. D.

12/19/1920 (Address) 422 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park Dec 20 1920

20 UNDERTAKER — ADDRESS

John O. Mitchell 1201 W. Fayette St

BEFORE CAUSE OF DEATH is filled in, read carefully instructions on back. CAUSE OF DEATH in plain terms. See instructions on Back. TION is very important.

ec.—6-9-19—H. P. Co.—1000 Bks.

D 49084 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 49084

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 917 Bradford ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Marguerite Killer

(a) RESIDENCE. NO. 917 Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 39 hours ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-16-1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		39 hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm J. Killer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Marguerite Reilly

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Wm J. Killer
(Address) 917 N Bradford St.

15 Filed DEC 20 1920 BOWLEY E FRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH IS PARTICULARLY REQUESTED TO READ CAREFULLY THE INSTRUCTIONS ON THIS CERTIFICATE. ATTENTION is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 16th, 1920, to Dec 18, 1920, that I last saw her alive on Dec 18, 1920, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Instrumental Birth - Position

Left Occipital Posterior (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Instrumental Birth Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm G. Smith, M. D.

12-17 1920 (Address) 1182 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 20 1920
20 UNDERTAKER J Kerwin & Co	ADDRESS 2008 Eutaw

Dec.—6-9-19—H. P. Co.—1000 Bks.

D49085 ✓ D49085

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

Dec 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Guilford ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline W Barrison.

(a) RESIDENCE. NO. 1602 Guilford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. 9 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William S Barrison

6 DATE OF BIRTH (month, day, and year) 3/8. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bucks Co. Penna.

PARENTS

10 NAME OF FATHER Isaac Twining

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ann Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Martha B. Curry.

(Address) 1602 Guilford Ave.

15 Filed DEC 20 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 18, 1920, that I last saw her alive on Dec 11th, 1920, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Insterstitial Nephritis

(duration) — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. R. Benson Jr. M. D.

Dec 19, 1920 (Address) Cockeysville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmount Harford Co. Md	12-20 1920
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	Orchard & McCulloh

CAUSE OF DEATH to be plainly written. DISEASE CONDITION is very important. See instructions on back of certificate.

D 49086 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Md. Gen. Hosp. St.: 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jacobs

(Residence in Baltimore: No. 435 Patapsco Brooklyn St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH: March 11, 1888 (Month) (Day) (Year)

7-AGE: 32 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): (Davison Chemical Co)

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John F. Jacobs.

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Amelia C Brawner

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Jacobs

(Address) 406 Patapsco Ave (Brooklyn)

15-

Filed DEC 20 1920 BY ROBERT B KRAUTER Registrar.

Burial Permit Issued

N.B.—Every item of information must be given, so that it may be entered in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 17 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of base of skull (24 hrs)

(See NOTE) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 18, 1920 (Address) 2802 Elfindale Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~~Md. Gen. Hosp.~~ yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Davison Chemical Co, Curtis Bay, Md.

Former or usual residence 435 Patapsco Ave.

19-PLACE OF BURIAL, OR REMOVAL: ORDAB HILL — DATE OF BURIAL: DEC 20 1920, 19....

20-UNDERTAKER: JOHN F. DENNY — ADDRESS: 715 LIGHT ST.

Co. (accidental)
Unavoidably accidental

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

Rec.—6-9-19—H. P. Co.—1000 Bks.

D49087 HEALTH DEPARTMENT—CITY OF BALTIMORE D49087

CERTIFICATE OF DEATH. 19 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 802 S. Bouldin ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bellman

(a) RESIDENCE. NO. 862 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Henry Bellman

6 DATE OF BIRTH (month, day, and year) March 1, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Yahn

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Not known

14 Informant Mrs Gertrude Yocum
(Address) 862 S. Bouldin St

15 Filed DEC 20 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from about 10-12 yrs ago to Dec 18, 1920, that I last saw her alive on Dec 18, 1920, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart & Cardiac hypertrophy
& valvular insufficiency
(dilatation of stomach) (duration) 10-12 yrs mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. W. Wright, M. D.

Dec 20, 1920 (Address) 3048 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Dec 21 1920
20 UNDERTAKER	ADDRESS
H. Vander & Son	1710 Fleet St.

CAUSE OF DEATH in plain terms. See instructions on back of CERTIFICATE. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49088 HEALTH DEPARTMENT—CITY OF BALTIMORE D49088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1722 N. Broadway ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Brockman

(a) RESIDENCE. No. 1722 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Brockman

6 DATE OF BIRTH (month, day, and year) April 1-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Lauterbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frederick W. Brockman (Address) 1722 N. Broadway

15 Filed DEC 20 1920 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1920 to Dec 16 1920 that I last saw h. alive on Dec. 16 1920 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 20 1920
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

matter should be written in plain terms. The CAUSE OF DEATH in plain terms. The CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49089 HEALTH DEPARTMENT—CITY OF BALTIMORE D49089

CERTIFICATE OF DEATH. 1920

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Foster Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Stahlin

(a) RESIDENCE. No. 3206 Foster Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Stahlin

6 DATE OF BIRTH (month, day, and year) April 11 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anton Stahlin (Address) 3206 Foster Ave

15 Filed DEC 20 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec 19, 1920, that I last saw her alive on Dec 18, 1920, and that death occurred, on the date stated above, at 3-50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) mrs J McAvoy M. D.

12/20, 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 22 1920
20 UNDERTAKER	ADDRESS
A. Vandeveer Son	1710 Eden St.

BURIAL PERMIT: Do not bury or remove from city without permit. CAUSE OF DEATH in plain terms. Name of disease not sufficient. See instructions on back of certificate. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D49090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49090

CERTIFICATE OF DEATH.

120 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Weldon Ave St., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Powell

(Residence in Baltimore: No. 1200 Weldon Ave St.; 40 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 17 (Day), 1850 (Year)

7-AGE, 70 yrs. 10 mos. 3 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Matthias Powell

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Eva. Flagd

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jane Powell

(Address) 1200 Weldon Av

15- Filed DEC 20 1920, 191.. ROBERT P. LAUTER Registrar.

CAUSE OF DEATH. Write plainly and use no abbreviations. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1st 1920, to Dec 18 1920, that I saw h in alive on Dec 18 1920, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) yrs. 11 mos. 12 ds.

CONTRIBUTORY (Secondary) myocarditis

(Duration) yrs. 3 mos. ds.

(Signed) S Krauss M. D.

Dec 20, 1920 (Address) 865 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Humphries | DATE OF BURIAL, Dec 21, 1920

20-UNDERTAKER A S Marshall | ADDRESS 3539 Falls Rd

Burial Permit Required.

D49091

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D49091

642

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 3001 Independence ST. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza J. Jenkins

(Residence in Baltimore: No. 3001 Independence St.: 26 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH June 15, 1837 (Month) (Day) (Year)

7-AGE 83 yrs. 6 mos. 4 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE (State or country) Dorchester Co. Md

PARENTS

10-NAME OF FATHER Jno Wheatley

11-BIRTHPLACE OF FATHER (State or country) Dorchester Co. Md

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Annie Conway

(Address) 3001 Independence St

15 DEC 20 1920 ROBERT B. ARAUTER

Filed ....., 191 ..... Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 19, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Dec 19 1920, that I saw h-- alive on Dec 19, 1920, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. G. Prentiss M. D.

..... 191 ..... (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cedar Hill	Dec 22, 1920

20-UNDERTAKER	ADDRESS
John F. Denny	715 Light St

N. B.-Every item of information should be carefully supplied. Examine the certificate before it may be properly classified. Especially state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

D49092 HEALTH DEPARTMENT—CITY OF BALTIMORE D49092

CERTIFICATE OF DEATH. 4 X 156

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 655 N. Fayette St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella Bryan

(Residence in Baltimore: No. Ruxton Balto Co Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, July 6 (Month), 6 (Day), 1875 (Year)

7-AGE, 45 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 637

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John L. Davis

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Maria Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John K. Bryan

(Address) Ruxton Md

15- DEC 20 1920 ROBERT E REAUTER

Filed....., 191.... Registrar

N. B.—Every item of information must be given, so that it may be properly recorded. CAUSE OF DEATH in plain terms, so that it may be properly classified and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said..... ~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) A few minutes

CONTRIBUTORY (Secondary) Suicide

(Duration)..... yrs. mos. ds.

(Signed) H. K. Grason M. D. (Coroner.)

12.20., 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oaklawn	Dec 21, 1920
20-UNDERTAKER Zerkler & Zerkler	ADDRESS 1734 E Lexington

D 49093 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49093

64

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. John S. Brooks, ST. 16 WARD)

2-FULL NAME 1071 N. Carey St.

(Residence in Baltimore: No. 1071 N. Carey St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Unknown (Month) (Day), 1880 (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Richard Brooks

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Adeline Washington

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. S. Brooks

(Address) 1071 N. Carey St.

15- DEC 20 1920 ROBERT J. KRAUTER
Filed ....., 191.... Registrar.
Burial Permit

N.B.—Every item of information should be given if possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(15 minutes)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 17, 1920 (Address) 2802 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, DEC 20 1920, 19..

20-UNDERTAKER [illegible]

ADDRESS 1303 FREEMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49094

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2730 Maryland Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Braeden

(a) RESIDENCE. No. 2730 Maryland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	18	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Jerome Braeden

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Murphy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Bessie Braeden
(Address) 2730 Maryland Ave

15 Filed ..... 19.... Registrar

DEC 20 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 20, to Dec. 18, 20,

that I last saw him alive on Dec 17, 20,

and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis, with
Followed by persistant Hiccough

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gall. Madness & Bashing

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. L. Smith, M. D.

12/16, 1920 (Address) 1605 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec 20 20

20 UNDERTAKER N. E. Hughes ADDRESS 424 N. Broadway

Robert L. Register
Burial Permit Clerk

mation should be given in plain terms. So that it will be understood by the public. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049095

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049095

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Jefferson ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cooper

(a) RESIDENCE. NO. 1408 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~5 yrs. 0 mos.~~ 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. Cooper

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 (apparently)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at her own home

(b) General nature of industry, business, or establishment in which employed (or employer) ~~—~~ 0

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Trap Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mollie Cooper (daughter)
(Address) 1408 Jefferson St.

15 Filed ....., 19 ..... Registrar

ROBERT E. KRAUTER
Burial Permit Clerk

DEC 20 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1920

17 I HEREBY CERTIFY, That I attended deceased from 11:30 A.M. 12/18, 1920, to 8 P.M. 12/18, 1920, that I last saw her alive on 12/18, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) ~~—~~ yrs. ~~—~~ mos. ~~—~~ ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~—~~

Did an operation precede death? no Date of ~~—~~

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam + Physical Exam

(Signed) Ralph F. Young, M. D.

, 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Dec 21 1920
20 UNDERTAKER Chas G Bailey	ADDRESS 1423 Jefferson Av

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

1049096 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049096

CERTIFICATE OF DEATH. 143 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 1 Monroe St. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia E Kilburn

(Residence in Baltimore: No. 1723 N Monroe St St.; 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Widow

6-DATE OF BIRTH, Mar 3, 1882 (Month) (Day) (Year)

7-AGE, 38 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Pordenton N J

PARENTS.

10-NAME OF FATHER, Francis Brinkley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Katherine Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Pordenton N J

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Brinkley

(Address) 1723 N Monroe St

15-

Filed DEC 20 1920 ROBERT I. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1920, to Dec 18 1920, that I saw her alive on Dec 18 1920, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Metastatic to Chest

Sepsis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O S Lloyd M. D.

Dec 18, 1920 (Address) 2233 Eaton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, Dec 20..., 1920

20-UNDERTAKER Martin Fahey & Sons | ADDRESS 827 W North Ave

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations or initials. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease causing it. Indefinite or incomplete answers cannot be accepted. If deaths from violence, state the nature of injury and whether accidental, suicidal or homicidal. If from accident, specify whether it occurred in mine, factory, railroad, etc. If a woman, whether single, married, widowed or divorced. If a child, whether legitimate or illegitimate. The above items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(New Rodgers) 1049097 1049097

CERTIFICATE OF DEATH.

28 REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Green Spring Av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward C Brookes

(Residence in Baltimore: No. Green Spring Av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1878 (Year)

7-AGE, 42 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gardiner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balto. Co

PARENTS.

10-NAME OF FATHER, Wm Brookes

11-BIRTHPLACE OF FATHER (State or Country) New York

12-MAIDEN NAME OF MOTHER Josephine Loomis

13-BIRTHPLACE OF MOTHER (State or Country) .....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine T. Brookes

(Address) Green Spring Av

15- Filed DEC 20 1920, 191.... EMMA F. KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Dec 20 191..., that I saw him alive on Dec 20 1920, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Pleurisy (chronic)

(Duration) ....yrs. 4 mos. ....ds.

(Signed) J. Blevaert M. D.

Dec 20, 1920 (Address) 2 Bidwell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Dec 21, 1920

20-UNDERTAKER Martin Fahey & Sons

ADDRESS 827 W North Av

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49098

CERTIFICATE OF DEATH.

1920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 S. Ellwood Ave (WARD) 1

2-FULL NAME Mary Michelmann

(a) RESIDENCE. No. 1012 S. Ellwood ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Michelmann

6 DATE OF BIRTH (month, day, and year) Feb. - 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	85	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. wife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Michelmann

(Address) 1012 S Ellwood ave

15 DEC 20 1920 BOBLE ... Registrar

Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to DEC 16, 1920, that I last saw h... alive on DEC 15, 1920, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchy. Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart + Oedema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) md. McAvoy, M. D.

19, 19 20 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel.	DEC. 20 1920
20 UNDERTAKER John A Moran Sons	ADDRESS E. Balto St

CAUSE OF DEATH in plain terms. ... on back of certificate. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49099 HEALTH DEPARTMENT—CITY OF BALTIMORE D49099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Mulberry St.; 4 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hughes.

(a) RESIDENCE. NO. 212 N Mulby St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Marrid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37 ds	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. Baltimore

PARENTS

10 NAME OF FATHER John Hughes Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Nannie Hughes (Address) 212 N Mulberry

15 Filed DEC 20 1920 19 ROBERT J. BRASTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 18, 1920, that I last saw him alive on Dec 18, 1920, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(duration) dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) dont Know if any

(duration) dont Kno yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Dr

(Signed) W K Gorsuch M. D.

12-20 1920 Address 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Dec 21 1920
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 N Mont

CAUSE OF DEATH must be filled in. See instructions on other side. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79D 49100

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 N Charles St. ; 17 WARD)

2-FULL NAME Maria E Hilburn

(a) RESIDENCE. No. 2614 N Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~ ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): March 11 1832

7 AGE: Years 88 | Months 9 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: John Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York.

14 Informant: Mrs Ed L Hilburn

(Address) 2224 N Charles St

15 Filed DEC 20 1920 19 ROSER J. PAVLIK Register

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): DEC 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1920, to DEC 19th, 1920, that I last saw h[illegible] alive on DEC 18th, 1920, and that death occurred, on the date stated above, at 1-45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) about 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) W A Faer M. D.

17 Dec 1920 (Address) 17 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 21 1920
20 UNDERTAKER	ADDRESS
Henry Weber & Sons Co	Richmond

CAUSE OF DEATH in plain terms, as directed on back of certificate. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Blks. George Hawreliuc. 1 H49101

HEALTH DEPARTMENT—CITY OF BALTIMORE

H49101 92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7225 Dallas ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hawreliuc

(a) RESIDENCE. No. 722 S. Dallas ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. George Hawreliuc

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER Unknown Hawreliuc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary Magyer

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant W. F. Sadowski
(Address) 705 S. Conn Pr.

15 DATE RECEIVED DEC 20 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-12. 1920, to 12-20 1920, that I last saw h.m. alive on December 12, 1920, and that death occurred, on the date stated above, at 12 03 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Harry A Rinkoff, M. D.

, 19 (Address) 1623 E Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Dec 21 1920
20 UNDERTAKER W. F. Sadowski.	ADDRESS 705 S. Conn

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D49102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49102

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Rollins

(a) RESIDENCE. NO. Formerly 1619 N. Gilmor St Baltimore Md } 29 yrs as resident ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? 29 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) —

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Baltimore Md

DEC 20 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1891, 19..., to Dec 18th, 1920., that I last saw him alive on Dec 17th, 1920., and that death occurred, on the date stated above, at 9 A., m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Mania (Epileptic)

abt (duration) 45 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

Dec 18, 1920 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 20 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Name of disease causing death must be stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49103 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49103

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Monticello ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Franklin Spruebank

(a) RESIDENCE. NO. 2204 Monticello Ave. ST.... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George W. Spruebank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto- md.

12 MAIDEN NAME OF MOTHER Mary S. Laguez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Havre

14 Informant (Address) Robert P. Harrison, JOHNS HOPKINS HOSPITAL.

15 Filed DEC 20 1920 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec-16, 1920, to Dec-18, 1920, that I last saw him alive on Dec 18, 1920, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature Birth.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? usual Phy. signs

(Signed) Bruce M. Grant, M. D.

19 (Address) 1206 W. Saratoga Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL DEC 20 1920

20 UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. H. WOOLLEY.

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

DEC 20 1920

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.49104

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49104

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 723 W. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Stephen & Caroline Gurcio

(a) RESIDENCE. NO. 723 W. Saratoga ST., 4th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17, 20

7 AGE — Years ..... Months ..... Days ..... If LESS than 1 day ..... hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ssd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U.S.

10 NAME OF FATHER Stephen Gurcio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Caroline Laguletta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

PARENTS

14 Informant .....
(Address) .....

15 Filed ..... 19 ..... Registrar

DEC 20 1920

Robert F. Harrison,
Burial Permit Clerk.

386

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to Dec. 17, 1920, that I last saw h[illegible] alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suspected Pregnancy (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Henry H. Weinberg, M. D.

, 19 (Address) 724 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Dec 20 1920

ADDRESS .....

20 UNDERTAKER

JOHNS HOPKINS HOSPITAL

Commissioner Health,

Per. Wm. H. WOODALL

pec.—6-9-19—H. P. Co.—1000 Bks.

0.49105 HEALTH DEPARTMENT—CITY OF BALTIMORE 2049105

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St.; 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hillman B. Tuttle

(a) RESIDENCE. No. 309 E. Lanvale St St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Wd.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) — 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not known

(b) General nature of industry, business, or establishment in which employed (or employer) " " 086

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER James Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Not any (Address)

15 Filed [illegible] 19 20 Registrar

DEC 20 1920

Burial Permit Clerk.

CAUSE OF DEATH. See instructions on reverse side. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1920, to Dec. 18, 1920, that I last saw h[illegible] alive on Dec. 18, 1920, and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Enlarged prostate
Chronic nephritis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute suppression urth
Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Wm K Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 20 1920 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.49106 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49106

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 120 Caroton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ball

(a) RESIDENCE. No. 120 Caroton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Fred Major

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ethel Ball

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant .....
(Address) .....

15 Filed DEC 20 1920 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920, to Dec 18, 1920, that I last saw h/m alive on Dec 18, 1920, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Premature
(34 wks child)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morris Reese, M. D.

12-19, 1920 (Address) Emergency Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 20 1920 19
20 UNDERTAKER Commissioner Health.	ADDRESS
Rec. Wm. E. WOODALL	

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificate.

D.49107 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49107

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~#15~~ St Andrew Hospital, WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Octave Hartman.

(Residence in Baltimore: No. 1815 St Paul St, St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... June (Month) 6 (Day), 84 (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 6 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... HW. 03
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Montgomery Co. Md.

PARENTS.

10-NAME OF FATHER, Wm A Green

11-BIRTHPLACE OF FATHER (State or Country), Montgomery Co.

12-MAIDEN NAME OF MOTHER Mary Celia Green

13-BIRTHPLACE OF MOTHER (State or Country), Mount Vernon

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas R. Horstman

(Address) 1815 St. Paul St

15- DEC 20 1920 Robert P. Harrison, 191.....

Registrar.

~~Burial Permit Clerk.~~

N. B.—Every item of DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Suicide by Pistol

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

12-20, 1920. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Gaithersburg Md	Dec 22 1920
20-UNDERTAKER	ADDRESS
W. H. Cook	502 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49108

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1715 Hanover ST. 23 WARD)

2-FULL NAME Infant of Mr & Mrs P. Sommerlatte

(a) RESIDENCE. No. 1715 Hanover ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 20/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balt & City
(State or country) Md.

PARENTS

10 NAME OF FATHER Percy H Sommerlatte

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie V. Deuck

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant P. H. Sommerlatte
(Address) 1715 Hanover St

15 DEC 21 1920 ROBERT I. LEANTEN Registrar

Burial Permit Otort

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 20, 1920, that I last saw h[illegible] alive on Dec 20, 1920, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 Mos Utero-Gestation)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. P. Campbell M. D.

12/20 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 21st 1920
20 UNDERTAKER	ADDRESS 1039
E. Schloman & Son	Hanover st

CAUSE OF DEATH to be filled in by physician. See instructions on back of certificate. TION is very important.

049109 HEALTH DEPARTMENT—CITY OF BALTIMORE 049109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1935 Pennsylvania ave ST.: 14th WARD) REGISTERED No. C 24

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Reeder

(Residence in Baltimore: No. 1935 Pennsylvania ave. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	married

6-DATE OF BIRTH, November 4, 1873
(Month) (Day) (Year)

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): (Laborer)

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, John S. Reeder

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Caroline Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Cooper

(Address) 1361 N. Carey St.

15- DEC 21 1920 ROBERT E KRAUTER
Filed ..., 19.. Registrar.
Burial Permit Issued

N. B.—Every item of information must be given, so that it may be complete and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. T. Henderson M. D.
(Coroner.)

Dec 20, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
SE Penn	Dec 23 1920
20-UNDERTAKER	ADDRESS
Clarence E. Wright	1364 Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

Andrzejczuk.

HEALTH DEPARTMENT CITY OF BALTIMORE

049110

049110

CERTIFICATE OF DEATH.

91-084

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 S Regester ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaw andrzejczuk

(a) RESIDENCE. NO. 705 S Regester ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Child~~ 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladyslaw Andrzejczuk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Zuzuk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Wladyslaus Andrzejczuk 705 S Regester St

15 Filed DEC 21 1920 ROBERT J. KRAMER, Registrar

Local Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-18, 1920, to 12-20, 1920, that I last saw h.m alive on 12-20, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis - Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Signs & Symptoms

What test confirmed diagnosis?

(Signed) John D Ruloff, M. D.

12/20 1920 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Dec 22 1920

20 UNDERTAKER John M Weber

ADDRESS 1803 Bank St

CAUSE OF DEATH must be given. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Zelichowska

d 49111 HEALTH DEPARTMENT—CITY OF BALTIMORE d 49111

CERTIFICATE OF DEATH 20

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 3

CITY OF BALTIMORE: (No. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teodora Zelichowska

(a) RESIDENCE. No. 818 E. Bond ST., WARD. Baltimore
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Zelichowski

11 BIRTHPLACE OF FATHER (city or town) ~~Austria~~ (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophie Olszoska

13 BIRTHPLACE OF MOTHER (city or town) ~~Russia~~ (State or country) Poland

14 Informant Sophia Zelichowska (Address) 818 Bond St

15 Filed DEC 21 1920 ROBERT F. FRAZIER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-20 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to Dec 20, 1920, that I last saw h[illegible] alive on Dec-19, 1920, and that death occurred, on the date stated above, at 7.25 A.m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) — yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No; Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) I. H. Sammenbaum, M. D.

12/20 1920 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 22 1920

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank St

CAUSE OF DEATH: ... TION is very important. See instructions on back of ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

049112 HEALTH DEPARTMENT—CITY OF BALTIMORE 049112

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 E Pratt St.: 3d WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agusta Katz

(a) RESIDENCE. No. 1523 E. Pratt St., 3d WARD.

(Usual place of abode)

Length of residence in city or town where death occurred abt 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiting Store 845

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Erlebacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nannetta Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob H Katz

(Address) 1523 E Pratt St

15 Filed DEC 21 1920 ROBERT E KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH IN ALL CASES. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Dec 19, 1920, that I last saw h alive on Dec. 17, 1920, and that death occurred, on the date stated above, at 9 45 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of left forearm

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A Rees, M. D.

Dec 22 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmonia Cem	Dec 21 1920
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

D49113 HEALTH DEPARTMENT—CITY OF BALTIMORE D49113

CERTIFICATE OF DEATH.

61

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST.; 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Roth

(Residence in Baltimore: No. 17 N. Milton Ave St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 5 (Day), 1863 (Year)

7-AGE: 57 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steamman
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE. (State or Country): Balto. City

PARENTS.

10-NAME OF FATHER: John Roth

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Nora Roth

(Address) 17 N. Milton ave

15- ROBERT B. BRAUTER

Filed DEC 21 1920 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 19 1920, that I saw h im alive on Dec 19 1920, and that death occurred, on the date stated above, at 8 05 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Meningitis

(a)

(b) Pneumococcus

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12-13-, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Dec. 22, 1920

20-UNDERTAKER Wm. H. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH. important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049114 HEALTH DEPARTMENT—CITY OF BALTIMORE 049114

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 900 E.North Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Ehrman

(a) RESIDENCE. No. 900 E.North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Ehrman

6 DATE OF BIRTH (month, day, and year) Mch.5.1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Gronau

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Stuhmann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Laura Ehrman (daughter(
(Address) 900 E.North Ave

15 DEC 21 1920 ROBERT E KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.18. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1920, to Dec 18, 1920, that I last saw h[illegible] alive on Dec 17, 1920, and that death occurred, on the date stated above, at 12:10 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] W. Sanderson, M. D.

, 19 (Address) 1714 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec.21 1920
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

CAUSE OF DEATH [illegible] TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+120 D49115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Williams

(a) RESIDENCE. No. 6926 Lowell Ave. - Chicago Ill ?? ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) ?, ?, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Thomas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Sarah Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant E. Williams (Address) 1305 Madison ave.

15 Filed DEC 21 1920 19 ROBERT P. KRAUTER Registrar

879

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1920, to Dec 13, 1920

that I last saw h/m alive on Dec 13, 1920

and that death occurred, on the date stated above, at 5.00 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman F. Abbott, M. D.

19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Dec. 22 1920

20 UNDERTAKER George L. Ruth — ADDRESS 735 Harford Av.

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D49116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 N. Broadway ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Bedford

(a) RESIDENCE. No. 901 N. Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Bedford

6 DATE OF BIRTH (month, day, and year): June 12, 1892

7 AGE — Years: 28 — Months: 6 — Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Staib

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Aloes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Robert Bedford

(Address): 901 N. Broadway

15 Filed DEC 21 1920 ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 19 20

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 20, to Dec 20, 19 20, that I last saw h..... alive on Dec 20, 19 20, and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(duration) ..... yrs. ..... mos. (6) ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas B. Eagle, M. D.

Dec 21; 19 20 (Address) 834 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Dec 23 19 20

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS 1739 Eager

mation shown in back of certificates.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back

D49117 HEALTH DEPARTMENT—CITY OF BALTIMORE D49117

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 638 E. Monument St.; 1 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Grzech
(Residence in Baltimore: No. 638 E. Monument St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), (Day), 1 (Year)

7-AGE, 50 yrs. mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland

PARENTS.
10-NAME OF FATHER, John Dzyk
11-BIRTHPLACE OF FATHER (State or Country), Poland
12-MAIDEN NAME OF MOTHER Regina Tulpe
13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Grzech
(Address) 638 E. Monument

15- Filed DEC 21 1920 ROBERT L. ARMSTEAD Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ....yrs....mos....ds.
CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) Henry Grau M. D.
(Coroner.)
Dec 21 1920 (Address) 1808 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus, DATE OF BURIAL, DEC 22, 1920,
20-UNDERTAKER W. F. Sadowski, ADDRESS 755 S. Ann.

N. B.—EVERY ITEM must be answered, or the certificate will be returned for completion. CAUSE OF DEATH in plain terms. Indefinite answers are worthless. Every certificate must be signed. Every item important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 49118 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49118

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. D. Weber Jr.

(a) RESIDENCE. NO. 3015 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ —

6 DATE OF BIRTH (month, day, and year) Sept 6/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Geo. D. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. D. Weber (Address) 3015 E. Monument

15 Filed DEC 21 1920 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 20, 1920, that I last saw him alive on Dec 19, 1920, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Cook, M. D.

12/20 1920 (Address) 413 E. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Dec 22 1920
20 UNDERTAKER Philip Herrig	ADDRESS 2016 Orleans

CAUSE OF DEATH IS very important. See instructions on reverse side.

Spec.—5-19-13—M. & T.—500 Bks.

049119 HEALTH DEPARTMENT—CITY OF BALTIMORE 049119

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Crawford Burns

(Residence in Baltimore: No. 578 W. Preston St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	married

6-DATE OF BIRTH, December (Month) 14 (Day) 1866 (Year)

7-AGE, 54 yrs. mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Horse Trainer
(b) General nature of industry, business, or establishment in which employed (or employer): Horse Training

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Gareth Burns.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Templeton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Francie Burns (Wife)

(Address) 2139 Division Street

15- Filed DEC 21 1920 191... ROBERT J. KRAUTER Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30th 1920, to Dec 20 1920, that I saw h... alive on Dec 19th 1920, and that death occurred, on the date stated above, at 12:50 P.m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emmett Farge M. D.

Dec 21st, 1920 (Address) 4 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Belair, Md.	Dec 21, 1920
20-UNDERTAKER Wm. M. Johnson	ADDRESS 1234 Etting St.

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49120 HEALTH DEPARTMENT—CITY OF BALTIMORE D49120

CERTIFICATE OF DEATH. 64-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Grindall ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Stratton

(a) RESIDENCE. NO. 208 Grindall ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Kate Stratton

6 DATE OF BIRTH (month, day, and year) March 13-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67 yrs.	9 mo.	6 ds.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Seabright N. J.

PARENTS

10 NAME OF FATHER Samuel Stratton

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Brunswick N J

12 MAIDEN NAME OF MOTHER Mary M Stuart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Morgantown N J

14 Informant William Auld. (Address) 239 Grindall St.

15 Filed DEC 21 1920 ROBERT I. TRAETEN Registrar

CAUSE OF DEATH must be stated by a physician, if he has been in attendance upon the deceased, or if he has not been in attendance, by the coroner. INFORMATION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Dec 19, 1920, that I last saw him alive on Dec 18, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical Diagnosis

(Signed) S E Burton, M. D.

12/19 1920 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec. 21 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 100 3 N. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

Catherine Hofstetter

HEALTH DEPARTMENT—CITY OF BALTIMORE

6 2049121

2049121

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Lady Hofstetter ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No 1 Furley ave 3rd Baltimore

(Residence in Baltimore: No. Furley ave Gardenville Md St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July (Month) 9 (Day), 1827 (Year)

7-AGE, 93 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Date Prince Ly

PARENTS.

10-NAME OF FATHER Lawrence Hofstetter Sr

11-BIRTHPLACE OF FATHER (State or Country). Balto Co Md

12-MAIDEN NAME OF MOTHER Mary Heberick

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hofstetter

(Address) Cor Bond St & North Ave

15- DEC 21 1920 ROBERT P. KRAUTER

Filed....., 191.... Registrar.

Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Dec 19 1920, that I saw h[illegible] alive on Dec 19 1920, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm H Gorsl M. D.

Dec 20 1920 (Address) Gardenville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lutz Cemetery Private

DATE OF BURIAL, Dec 22 1920

20-UNDERTAKER H. C. Wiedefeld Sr

ADDRESS Greenmount Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49122

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 947 S. Linwood Ave. (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam C Pfeufer.

(a) RESIDENCE. No. 947 S. Linwood Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Pfeufer.

6 DATE OF BIRTH (month, day, and year) Nov. 18—1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired MD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Pfeufer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret C. Pfeufer.
(Address) 947 S. Linwood Ave

15 Filed DEC 21 1920 ROBERT E. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15 1920, to Dec 18th 1920, that I last saw him alive on Dec. 18th 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Atheroma

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) D. W. Jones, M. D.

12/20. 1920 (Address) 1013 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 22 1920
20 UNDERTAKER Lilly & Zirkin.	ADDRESS 403 S. Wolfe

CAUSE OF DEATH IN [illegible] TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49123

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3910 E. Pratt St ST.; 26 WARD)

2-FULL NAME James H. Ensor

(a) RESIDENCE. NO. 3910 E. Pratt St ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Ensor

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Ida Fisher
(Address) 3910 E. Pratt St.

15 DEC 21 1920 ROBERT E. KRAUTER Registrar
Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1920, to Dec. 20, 1920, that I last saw h... alive on Dec. 19, 1920, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 1910 (Address) 922 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Dec. 23 1920

20 UNDERTAKER: Filby and Zeile.

ADDRESS: 403 S. Mo...

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

pec.—6-9-19—H. P. Co.—1000 Bks.

D.49124 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49124

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 519 Robert st ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Branch

(a) RESIDENCE. NO. 519 Robert st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: Colord

5 ~~Single, Married,~~ Widowed, ~~or Divorced (write the word)~~: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE ~~About~~ ~~Dead~~ Years: 60+ Months: - Days: - If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Na

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Chas H Johnson
(Address) 519 Robert st

15 Filed DEC 21 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-20 1920

17 I HEREBY CERTIFY, That I attended deceased from about 1 yr ago Past to Dec 20 1920; that I last saw her alive on Dec 17 1920 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cancer of the Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H K Tyson M. D.

Dec 20 1920 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Dec. 22 1920

20 UNDERTAKER: Geo H Holland

ADDRESS 1631 Lemmon Ave

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN IF POSSIBLE. See instructions. TION is very important.

Rec.—6-9-19—H. P. Co.—1000 Bks.

D.49125 ✓D.49125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Gadow (Rita Gadow)

(a) RESIDENCE. NO. 1016 E Chase ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12, 17 20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt city

PARENTS

10 NAME OF FATHER Russell Gadow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Reidl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt city

14 Informant Mr. Russell Gadow

(Address) 1016 E Chase St

15 Filed DEC 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec 21, 1920, that I last saw h[illegible] alive on Dec 21, 1920, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Combined Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Kenton, M. D.

12 21 20 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery G.A.S.	Dec. 21 1920
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager St

TION is very important. Se[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49126

CERTIFICATE OF DEATH.

42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Gough ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Wilkinson

(a) RESIDENCE. NO. 1808 a Gough ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Archibald Wilkinson

6 DATE OF BIRTH (month, day, and year) Feb 26 - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Chas. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Kate Lewis (Address) 1808 Gough St

15 Filed DEC 21 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19. 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to Dec 19, 1920, that I last saw h.e alive on Dec 19, 1920, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Uterine Carcinoma

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 12. 20

Was there an autopsy? No.

What test confirmed diagnosis? Hospital

(Signed) Geo. Keller, M. D.

12-21, 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	12/22 19 20
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore

CAUSE OF DEATH must be given. See instructions on back. TION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D.49127 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49127

92-19

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., WARD)

2-FULL NAME Frank Trainor

(a) RESIDENCE. NO. 2307 E Madison ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? ? ? 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Patrick Trainor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country) " "

14 Informant Mrs Price
(Address) 2307 E. Madison St

15 Filed DEC 21 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF ... TION is very important. See instructions ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/ 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 18, 1920, to Dec 19, 1920, that I last saw him alive on Dec 19, 1920, and that death occurred, on the date stated above, at 7.20P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 9 mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General findings

(Signed) Frank C Trainor, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Cathedral Cem	12/22 1920
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore St.

D.49128 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49128

CERTIFICATE OF DEATH.

X 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lemon Station Md St. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Freeland

(Residence in Baltimore: No. 78 Newark Md. N. Y.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug. 27, 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Richard Freeland

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Mary E. Young

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Freeland

(Address) Waverly Pla.

15-

Filed DEC 21 1920, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information called for is important, so that it may be entered in the CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 19, 1920 (Address) 1637 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 month yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL, Dec 22, 1920

20-UNDERTAKER Robt P. Harrison

ADDRESS 1727 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D.49129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49129

92

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 583 Walnut ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Peaker

(Residence in Baltimore: No. 583 Walnut St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June ....., 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Marshall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Florence Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Marshall

(Address) 583 Walnut St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

DEC 21 1920 Burial Permit Clerk

CAUSE OF DEATH. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18- 1920, to Dec 19- 1920, that I saw h[illegible]alive on Dec 18- 1920, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) None Known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Keller M. D.

Dec 20, 1920. (Address) 222 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 22, 1920

20-UNDERTAKER John H Tradine — ADDRESS 142 Hull St

D.49130 HEALTH DEPARTMENT--CITY OF BALTIMORE D.49130

CERTIFICATE OF DEATH

154

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1045 Brantley ave St.: 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Peacock

(Residence in Baltimore: No. 1045 Brantley Ave St.; 4yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female

4-COLOR OR RACE W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH March McKnown (Month) (Day), 1830 (Year)

7-AGE 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or country) Balto Md

PARENTS

10-NAME OF FATHER McKnown

11-BIRTHPLACE OF FATHER (State or country) Penna Middletown

12-MAIDEN NAME OF MOTHER Mary Wise

13-BIRTHPLACE OF MOTHER (State or country) Middletown Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Duncan

(Address) 1045 Brantley Ave

15- Robert P. Harrison, Burial Permit Clerk REGISTRAR

DEC 21 1920 ....., 191.....

B.-Every item of information must be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 20" (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1920 to year 191..., that I saw h alive on Dec 20 1920 and that death occurred, on the date stated above, at 11 7. P m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(Duration) yrs. mos. ds

Contributory (SECONDARY) Weak Heart

(Duration) yrs. mos. ds.

(Signed) W B Ryder M. D.

Dec 21, 1920 (Address) 867 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park

DATE OF BURIAL 12-22, 1920

20-UNDERTAKER H. C. Cunningham

ADDRESS 5711 Belmont st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49131 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49131

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 883 W. Franklin St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Frozner

(a) RESIDENCE. NO. 883 W Franklin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath Md

PARENTS

10 NAME OF FATHER Louis A Frozner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath Md

12 MAIDEN NAME OF MOTHER Matilda Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa

14 Informant L A Frozner (Address) 883 W Franklin St

15 Filed DEC 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec 21, 1920, that I last saw her alive on Dec 20, 1920, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis with Scarlet fever

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H R Forman, M. D.

Dec. 21 1920 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	12-22 1920
20 UNDERTAKER H. C. Brauning Son	ADDRESS 677 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Blks.

D.49132 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49132

CERTIFICATE OF DEATH.

28 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 John ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tolson T. Wellmore

(Residence in Baltimore: No. 1415 John St.; 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 21, 1874 (Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Stationary 066

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Eward Wellmore

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Josephine Maher

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Mullen 2nd

(Address) 1020 W. Calvert St.

15- DEC 21 1920 Robert P. Harrison, ..., 191..... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1920, to Dec 21 1920, that I saw him alive on Dec 20 1920, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Fibroid Phthisis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of Pharynx

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) William L. Mullen M. D.

Dec 21, 1920 (Address) 1020 W. Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, 12/23, 1920.

20-UNDERTAKER Henry W. Meas & Son — ADDRESS 805 W. Calvert St

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 49133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49133

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N Baltimore St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A Mastroman

(a) RESIDENCE. No. 1323 N. Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A Mastroman

6 DATE OF BIRTH (month, day, and year) June 10th 1833

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	87-	6	1-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ostra bruck Germany

PARENTS

10 NAME OF FATHER A Garza Kok

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theo A Mastroman

(Address) 3110 Auchentorly Terrace

15 Filed DEC 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Dec 20, 1920, that I last saw h alive on Dec. 20, 1920, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Old age -

fading for 1 yrs. 6 mos. X ds.

(duration)

CONTRIBUTORY (Secondary) (Static) Pneumonia

due to age (duration) 1 yrs. X mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) R. Bellson, M. D.

12/20, 19 (Address) 1124 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: DEC 22nd 1920

20 UNDERTAKER: Wm J Hartwell.

ADDRESS 2286 W. Baltimore St

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificate.

...c.—6-9-19—H. P. Co.—1000 Bks.

D.49134 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49134

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Brighton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bertram Sr

(a) RESIDENCE. No. 2916 Brighton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? Mtknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Sept 23 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	77	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mknown

12 MAIDEN NAME OF MOTHER Mknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mknown

14 Informant (Address) Chas Bertram 2916 Brighton St

15 Filed ..... 19 Robert P. Harrison, Registrar

DEC 21 1920

Burial Permit Clerk.]

CAUSE OF DEATH
TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-20 - 1920

17

I HEREBY CERTIFY That I attended deceased from Nov-24, 1919, to Dec-20, 1920, that I last saw him alive on Dec-20, 1920, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Senile)

Aspnea (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dilatation.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Hosley Cole, M. D.

, 19 (Address) 2702 Harrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ridge Cemetery	Dec 23 1920
20 UNDERTAKER H. E. Eichelberger Sons	ADDRESS Walbrook

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49135 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49135

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 W) Franklin ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa J. Schirm

(a) RESIDENCE. No. 1505 W. Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Schirm

6 DATE OF BIRTH (month, day, and year) May 21 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fredk. Hesse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — Deuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kellie E. Krantz

(Address) 1505 W. Franklin St

15 Filed DEC 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1919, to Dec 21, 1920, that I last saw h er alive on Dec 21, 1920, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy. —

two hours,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis + arteriosclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M Bruncrook, M. D.

Dec 21. 1920 (Address) 624 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 24 1920
20 UNDERTAKER	ADDRESS
Wm Tecklenburg Sons	No 411 St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 28 [illegible]

049136

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1208 Sargeant ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. Rooney

(a) RESIDENCE. NO. 1208 Sargeant St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life time (If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 20 1897

7 AGE — Years: 23 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry worker

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Jas. J Rooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Riener

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Henry Riener 1208 Sargeant St

15 Filed DEC 22 1920 ROBERT F. LUCAS Registrar

16 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920, to Dec 19, 1920, that I last saw her alive on Dec 18 1920 and that death occurred, on the date stated above, at 10 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous infection of Larynx (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) W. G. Zinsinger M. D.

12/21/20 (Address) 682 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 23 1920

20 UNDERTAKER: Geo Lewis Lusby & Son — ADDRESS: Fremont Ave

CAUSE OF DEATH. See instructions on back of this TION is very important.

D49137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49137

CERTIFICATE OF DEATH.

1PLACE OF DEATH

CITY OF BALTIMORE (No. 1 W. Hughes St. ST.: 22 150 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Stuart. (C)

(Residence in Baltimore: No. 1 W. Hughes St. St.: yrs. --- mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, December 19th. 1920., 1.....
(Month) (Day) (Year)

7-AGE, ---yrs.---mos.1...ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Stuart. (C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Pauline Johnson. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Stuary. (C) mother.

(Address) 1 W. Hughes St.

15-DEC 22 1920 ROBERT N KRAUTER
Filed....., 191... Burial Permit Clerk
Registrar.

N. B.—Every item must be filled in. Write plainly. Use ink. Spell out CAUSE OF DEATH in plain terms, so that it may be understood. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.
Congenital.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) Walter Reinhardt M. D.
(Coroner.)

Dec 20 20, 1920. (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn et	Dec 21..., 1920
20-UNDERTAKER	ADDRESS
H. L. Brown & Son	109 W Monte

Dec.—6-9-19—H. P. Co.—1000 Bks.

D49138 HEALTH DEPARTMENT—CITY OF BALTIMORE D49138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 E 21st ST. 126 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kehr

(a) RESIDENCE. NO. 19 E 21st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Kehr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Moller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Kehr
(Address) Brooklyn City

15 Filed DEC 22 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 14, to Dec 20, 1920.
that I last saw h.r alive on Dec 19, 1920,
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Interstitial Nephritis (chronic)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia 6

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Laboratory tests

(Signed) Benjamin Pettit M. D.

19 (Address) 2134 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	12-22 1920

20 UNDERTAKER Mrs Chas A. J. Rohde

ADDRESS 600 N Arlington Ave

CAUSE OF DEATH must be filled in. See instructions on back of this TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D49139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49139

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home Hope Retreat ST. 12 WARD)

2-FULL NAME Lucy Frederick

(a) RESIDENCE. No. Formerly 336 E. 27th St Baltimore ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Mr Frederick

6 DATE OF BIRTH (month, day, and year) Unknown 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Belt

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mrs Bannon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Records of Hope Retreat (Address) Mt Hope Md

15 DEC 22 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH in plain words. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1919, to Dec 21. 1920, that I last saw her alive on Dec. 20. 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis. (R. Hemoplegia)

abt (duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Dementia -

(duration) 1 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D

, 19 (Address) Home Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	12-23 1920
20 UNDERTAKER	ADDRESS
Wm Elias & G Rohde	Washington

Spec.—6-9-19—H. P. Co.—1000 Blks.

0949140 HEALTH DEPARTMENT—CITY OF BALTIMORE 0949140

CERTIFICATE OF DEATH.

8 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2239 E Preston ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Heitmuller

(a) RESIDENCE. NO. 2239 E Preston ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Baltimore yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Heitmuller

6 DATE OF BIRTH (month, day, and year) Dec 28 1835

7 AGE 84 Years 11 Months 23 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper Hissler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Ulrich (Address) 2239 E Prestons

15 Filed DEC 22 1920 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1920, to Dec 21, 1920,

that I last saw her alive on Dec 21, 1920,

and that death occurred, on the date stated above, at 4 pm.

The CAUSE OF DEATH* was as follows:

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) A. E. Hansen, M. D.

Dec 22, 1920 (Address) 1301 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 24 1920
20 UNDERTAKER	ADDRESS
Louis Heemann	32 N Broadway

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. Ages should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. See instructions on back of certificates. TION is very important.

049141 HEALTH DEPARTMENT—CITY OF BALTIMORE 049141

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 616 Bartlett Ave ST.) 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Creswell.

(Residence in Baltimore: No. 616 Bartlett Ave. St. Left mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married.

6-DATE OF BIRTH, April 19, 1869. (Month) (Day) (Year)

7-AGE, 51 yrs. 8 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Slag Roofer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George Creswell.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Dolan.

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Creswell.

(Address) 616 Bartlett Ave

15- Filed DEC 22 1920 191.. ROBERT P KRAUTER Clerk. Burial Permit Issued.

N. B.—Every item must be filled in plain terms, so that it may be important. See instructions on back of certificate. CAUSE OF DEATH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

12-22, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Marys Roland Ave. DATE OF BURIAL, 12-24, 1920.

20-UNDERTAKER William Cook ADDRESS 504 E. North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049142 HEALTH DEPARTMENT—CITY OF BALTIMORE 049142

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 228 S. Ann ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Hartman

(a) RESIDENCE. NO. 228 S. Ann ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hartman.

6 DATE OF BIRTH (month, day, and year) Nov. 6th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. of ..... min.
	55	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Schleininger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ambrosius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Hartman (Address) 228 S. Ann St.

15 Filed DEC 22 1920 ROBERT A KRAUTER Registrar

Burial Permit 01071

CAUSE OF DEATH to be plainly written. TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19th, 1920, to Dec. 20th, 1920, that I last saw her alive on Dec. 20th, 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 23rd 1920

20 UNDERTAKER Lilly & Zeller ADDRESS 608 S. Wolfe

D49143 HEALTH DEPARTMENT—CITY OF BALTIMORE D49143

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St. Joseph Hospital ST.: 13 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caetano Mineto

(Residence in Baltimore: No. 3645 Chestnut-St. St.) yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 13, 1868
(Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Peter Cross

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Asked Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Asked Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Minuta

(Address) 3343 Chestnut Ave

15-

Filed DEC 22 1920 [illegible] KRAUTER Registrar.

Special Form C 0XXX

CAUSE OF DEATH in plain terms. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of Brain
probably due to
Auto Accident (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. K. Ensley M. D.
(Coroner)

181 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 23, 20
20-UNDERTAKER	ADDRESS
A. Marshall	353 Fallsway

Spec.—8-24-14—M. & T.—2000 Bks.

049144 HEALTH DEPARTMENT—CITY OF BALTIMORE 049144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3505 Reastestown Rd St.; 15 WARD)

REGISTERED No. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albertina B Jahelka

(Residence in Baltimore: No. 3505 Reisterstown Rd St.; 25 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb (Month) 24 (Day), 1892 (Year)

7-AGE. 28 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Switzland

PARENTS.

10-NAME OF FATHER, William Jahelka

11-BIRTHPLACE OF FATHER (State or Country) Switzland

12-MAIDEN NAME OF MOTHER Johana Pultz

13-BIRTHPLACE OF MOTHER (State or Country) Switzland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Johana Jahelka

(Address) 3505 Reisterstown Rd

15- Filed DEC 22 1920, 191.... ROBERT B KRAUTER Burial Permit Officer. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 29 1920, to Dec 21 1920, that I saw her alive on Dec 20 1920, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Laryngeal Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 4 ds.

(Signed) W O Smith M. D.

Dec 21, 1920 (Address) 3429 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Dec 23, 1920

20-UNDERTAKER A D Maskell ADDRESS 3539 Falls Rd

CAUTION—Every question must be answered if possible. Physicians and others are requested to co-operate with the Registrar in securing prompt and complete returns. Read carefully the instructions on back of certificate. Every item is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D49145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49145

CERTIFICATE OF DEATH.

40 D49145

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Lewis Schaefer

(Residence in Baltimore: No. 1010 W. Lanvale St.; 72 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. (Month) 23 (Day), 1848 (Year)

7-AGE, 72 yrs. 2 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Reinhard Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Annie C. Knoch

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Schaefer

(Address) 2512 N. Calvert St.

15- Filed ... DEC 22 1920 ... 19... Burial Permit Issued ... Registrar. ROBERT E KRAUTER

DEC 22 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 18th 1920, to Dec 19th 1920, that I saw h.m alive on Dec 19th 1920, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) ... yrs. 11 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edw. J. Summer M. D.

Dec. 19, 1920 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec. 22, 1920

20-UNDERTAKER John D. Mitchell ADDRESS 1201 W. Fayette St.

Use this side. See instructions on back if important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D49146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.: 16 WARD)

2-FULL NAME Margaret Peach

(a) RESIDENCE. NO. 1016 Ashburton Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Peach

6 DATE OF BIRTH (month, day, and year) Unknown 1868

7 AGE: 52 (Years / Months / Days; If LESS than 1 day, ... hrs. or ... min.)

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Thomas Doory

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Connolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm Peach
(Address): Granite Md

15 Filed ..... 19.. ROBERT E. SLAUTER Registrar

DEC 22 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1920, to Dec 20, 1920
that I last saw her alive on Dec 20, 1920,
and that death occurred, on the date stated above, at 6 05 P. m.
The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood Tests

(Signed) P. W. Kourey, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Dec 1920
20 UNDERTAKER: Martin Fahey & Sons	ADDRESS: 1827 W Mulberry St

CAUSE OF DEATH. See instructions on back. ATION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D 49147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49147

CERTIFICATE OF DEATH.

REGISTERED No. C 18120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 West Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Custus

(Residence in Baltimore: No. 1026 West Lexington St. 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 1 (Day), 1876 (Year)

7-AGE, 44 yrs. 6 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Transfer man
(b) General nature of industry, business, or establishment in which employed (or employer): Moves furniture

9-BIRTHPLACE, (State or Country), Accomac Co Eastern Shore Va

PARENTS.

10-NAME OF FATHER, Jacob Custus

11-BIRTHPLACE OF FATHER (State or Country), Accomac Co Eastern Shore Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Eastern Shore Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Maggie Custus

(Address) 1126 W. Lexington

15-

Filed DEC 22 1920, 191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 7 1920, to December 18 1920, that I saw h[illegible] alive on December 18 1920, and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease & Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(Duration) yrs. mos. ds.

(Signed) W. H. E. Campbell M. D.

Dec. 21, 1920 (Address) 1369 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec. 22, 1920

20-UNDERTAKER Samuel Hensley ADDRESS 378 N. Eddel St.

CAUSE important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49148 — 79 D 49148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (NO. 620 Warner ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Burgess

(a) RESIDENCE. NO. 620 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Perry Burgess

6 DATE OF BIRTH (month, day, and year) — 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House Work.

(c) Name of employer Mrs. Isaac Griffith

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co. Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sulu Young (Address) 620 Warner St.

15 Filed DEC 22 1920, 19.... ROBERT I. PRATHER Registrar

Burial Permit Clerk

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 20, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct, 31, 1920, to Dec, 20, 1920, that I last saw her alive on Dec, 19, 1920 and that death occurred, on the date stated above, at 8 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Francis M. D.

Dec, 22, 1920 (Address) 1111 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Dec 23 1920

20 UNDERTAKER John H Frazier ADDRESS 412 N Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49149

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Georgetown Rd Union Ave St. Morrell Park 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Congdon

(a) RESIDENCE. No. Georgetown Rd Union Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902 - July 13

7 AGE: Years 18 | Months 5 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone operator

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry Condon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Theresa Rapeis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Henry Condon
(Address): Georgetown Union Ave

15 Date: DEC 22 1920

ROBERT B. BRAUER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/20/20.

17

I HEREBY CERTIFY, That I attended deceased from 12/2, 1920, to 12/20, 1920, that I last saw her alive on 12/20, 1920, and that death occurred, on the date stated above, at 8300 m.

The CAUSE OF DEATH* was as follows:

Tbc Coping Pulmonary
Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Respiratory paralysis

Pulmonary oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted, if not at place of death? Georgetown Rd Union Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical tests

(Signed) Damon P. Alonzo M. D.

. 19 (Address) 336 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral Cem | DATE OF BURIAL: Dec 24 1920

20 UNDERTAKER: Wm Cook & Son | ADDRESS: E North

CAUSE OF DEATH TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49150

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1641 North Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kemp

(a) RESIDENCE. NO. 1641 N. Carey ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Kemp

6 DATE OF BIRTH (month, day, and year) Jul 24 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Garage. 06

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Obidah Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Isabella Kemp

(Address) 1641 N Carey

Filed DEC 22 1920 ROBERT J. KRAUTER Registrar

Burial Permit 01877

CAUSE OF DEATH. See instructions on this page. IMPORTANT. It is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/20

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1920, to Dec 20, 1920, that I last saw h.. alive on Dec 20 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cirrhosis Liver with Bronchitis

(duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Examination & treatment

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas H. Burbert, M. D.

, 19 (Address) 1102 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL 12/22 1920

20 UNDERTAKER William Corl — ADDRESS 5076 York

...—6-9-19—H. P. Co.—1000 Blks.

D49151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49151

108

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. St Joseph Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Duffy

(a) RESIDENCE. NO. 1022 Boyd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M.

5a If married, widowed, or divorced HUSBAND of - (or) WIFE of Mary Reynolds Duffy

6 DATE OF BIRTH (month, day, and year) Oct 15th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	34.	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman for self

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph. Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Donnelly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Mary Reynolds Duffy (Address) 1022 Boyd St.

15 Filed DEC 24 1920 ROBERT A KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH IS very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920 to Dec 20, 1920 that I last saw h— alive on Dec 20, 1920 and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* was as follows:

Generalized Peritonitis

About 10 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) 10 days yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. A. Schumacher, M. D.

, 19 (Address) St Joseph's Hosp Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Holy~~ New Cathedral Cem. DATE OF BURIAL Dec 24th 1920

20 UNDERTAKER John J. Gawan & Son ADDRESS 901 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49152 HEALTH DEPARTMENT—CITY OF BALTIMORE D49152

D49152 CERTIFICATE OF DEATH. 79 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 Cornell Av, ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susana E LaBon

(a) RESIDENCE. NO. 1446 Cornell Av ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Charles E. LeBon

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE: Years 81 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Cockey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr Chas W LeBon

(Address): 814 W Mt

Filed DEC 22 1920, 19 Burial Permit Oler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 21. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 21, 1920, that I last saw h[illegible] alive on Dec 21, 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dorsey, M. D.

, 19 (Address) 1227 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem. | DATE OF BURIAL: Dec 23rd, 1920

20 UNDERTAKER: John J Cowan & Son | ADDRESS: 501 Holliday St

CAUSE OF DEATH MUST be given. If unknown, state so. Omission to do this is a misdemeanor. See instructions on back of this blank. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

049153

049153

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 822 Lexington ST. 13 WARD)

2-FULL NAME Anna K. Schultze

(a) RESIDENCE. NO. 822 Lexington ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Schultze

6 DATE OF BIRTH (month, day, and year): Jan 6 1855

7 AGE: Years 65; Months 11; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frederick Ochmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Doterich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William J. Schultze (Address) 822 Lexington Ave.

15 Filed DEC 22 1920 MOLLY J. KRAUTER Registrar Burial Permit Clerk

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Dec 20, 1920, that I last saw he alive on Dec 20, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Pylorus Ind.

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John R. Abercrombie M. D.

, 19 (Address) 1316 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation. London Park

DATE OF BURIAL: Dec 23 1920

20 UNDERTAKER: Mrs. Mrs John W. Tenfel

ADDRESS: 801 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49154 ✓ D.49154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount Av ST.: 4 WARD)

2-FULL NAME Mrs. Mary Wallin

(a) RESIDENCE. NO. Wentworth Apts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Wallin

6 DATE OF BIRTH (month, day, and year) May 7, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Patton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Nolan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Herman Wallin
(Address) Wentworth Apartments

15 DEC 22 1920 19 Robert Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec. 22, 1920, that I last saw h.er alive on Dec. 22, 1920, and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Carbuncle of upper lip

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Septic pneumonia

(duratien) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 19-1920

Was there an autopsy? No

What test confirmed diagnosis? Operation + Lab. Tests

(Signed) Richard G. Coblentz, M. D.

, 19 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery, Phila.	12/22 1920
20 UNDERTAKER Henry W. Mears & Son 805	ADDRESS W. Calvert

Escort Harrison Park Clerk.

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

D.49155 HEALTH DEPARTMENT---CITY OF BALTIMORE D.49155

CERTIFICATE OF DEATH

79

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Athol Terrace ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Hamilton

(Residence in Baltimore: No. Athol Terrace St.; 63 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH May (Month) 21 (Day), 1824 (Year)

7-AGE 96 yrs. 7 mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired for
(b) General nature of industry, business, or establishment in which employed (or employer): 25 Years Dad

9-BIRTHPLACE (State or country) Edenburg Scotland

PARENTS

10-NAME OF FATHER Thomas Hamilton

11-BIRTHPLACE OF FATHER (State or country) Scotland

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or country) not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Kellam Hamilton

(Address) Athol Terrace

15- Robert P. Harrison,

Filed DEC 22 1920 191 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH December (Month) 21 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 17, 1920, to Dec 21 1920, that I saw h.. alive on Dec. 21 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Pulmonary oedema

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Henry J Hahn M. D.

Dec. 22, 1920 [Address] 23 W Franklin St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL Dec. 23, 1920

20-UNDERTAKER Wagner & Schmuck

ADDRESS White Hall & Edmondson Ave

state CAUSE OF DEATH fully. Omission of this information may delay burial certificate. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49156 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49156

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Annison

(a) RESIDENCE. No. 210 S. High st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Sam Annison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) M.T.H. JOHNS

Filed DEC 22 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1920, to Dec. 20, 1920, that I last saw him alive on Dec. 20, 1920, and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) [signature] M. D.

12-21-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL DEC 22 1920

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.49157

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.49157

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Hill

(a) RESIDENCE. NO. Sparrows Point, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steel company

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Patrick Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records

Filed Dec 22 1920, 19 Robert F. Harrison, JOHNS Registrar

Burial Permit Clerk.

DEC 22 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1920, to Dec. 18, 1920, that I last saw him alive on Dec. 18, 1920, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) H. H. Kiger, M. D.

12-18-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: DEC 22 1920

20 UNDERTAKER: Commissioner Health.

ADDRESS

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49158 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49158

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thompson

(a) RESIDENCE. No. 1108 Low St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt. Hall (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 18, 1920, that I last saw h[illegible] alive on Dec 18, 1920, and that death occurred, on the date stated above, at 3:35 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? [illegible]

(Signed) Guy N. Cromwell, M. D.

12/20, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 22 1920 19
20 UNDERTAKER	ADDRESS

Commissioner Health,

Per. Wm. H. WOODALL

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49159 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.) 8 (WARD)

REGISTERED No. 150

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Smallwood

(a) RESIDENCE. No. 1818 N. Durham St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1st yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			19 hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Smallwood

11 BIRTHPLACE OF FATHER (city or town) Del.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Pierce

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Hospital Record
(Address) Johns Hopkins Hosp.

15 Filed , 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec 18, 1920, that I last saw h[illegible] alive on Dec 18, 1920, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Dec. 17, 1920

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W Davidson, M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DEC 20 1920

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Burial Permit Clerk

IMPORTANT. See instructions on back. CERTIFICATE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Female ✓

D49160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102 D49160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Martin.

(a) RESIDENCE. NO. 2911 Taylor St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Christina Martin

6 DATE OF BIRTH (month, day, and year) March 21 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer) Quarries
(c) Name of employer City Quarrying Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lena Poleott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Christina Martin
(Address) 2911 Taylor St

15 Filed DEC 22 1920 Registrar
Burial Permit Clerk

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 — 12-21-20 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18- 1920, to December 21, 1920, that I last saw him alive on Dec. 21, 1920, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronco pneumonitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Gastric Ulcer with Peritonitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-18-20.

Was there an autopsy? No.

What test confirmed diagnosis? History; Physical; Operation

(Signed) W. C. Deaktyner, M. D.

12-21, 1920 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Merion Cemetery

DATE OF BURIAL Dec 24 1920

20 UNDERTAKER Wendell Dypert & Son

ADDRESS 878 N

Spec.—6-9-19—H. P. Co.—1006 Bks.

D. 49161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49161

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schnellenberger

(a) RESIDENCE. No. 743 St. Helena St., Ward. St. Helena Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Julia Schnellenberger

6 DATE OF BIRTH (month, day, and year) April 19, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42		8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital records.

(Address)

15 Filed DEC 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1920, to Dec 21, 1920, that I last saw him alive on Dec. 26, 1920, and that death occurred, on the date stated above, at 1:00 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis of Insane

(duration) yrs. mos. ds.

OVER

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Tests & Symptoms

(Signed) Dr. B. C. Mebane, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Dec 23rd 1920
20 UNDERTAKER	ADDRESS 1389
E Schlomanson	Hanover

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Pks.

D. 49162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49162

104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2645 Frederick Av ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs E. Harfield

(a) RESIDENCE. NO. 2645 Frederick Av ST. 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5th 1919

7 AGE: Years / Months — Days 16 If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Carroll E. Harfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Richard E. Lether

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Carroll E. Harfield (Address) 2645 Frederick Av

15 Filed DEC 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1920, to Dec 21st, 1920, that I last saw him alive on Dec 21st, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Acute Gastro-Enteritis

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

What was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. S. Culbertson, M. D.

(Address) 1800 Linden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 23 1920

20 UNDERTAKER: F. D. Hilpert — ADDRESS: 2256 Frederick Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49163 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49163

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH REGISTERED No. .....

CITY OF BALTIMORE: (No. # 140 Collings Av St. 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrique Schubert

(a) RESIDENCE. No. 140 Collins Av ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Chas F. Schubert

6 DATE OF BIRTH (month, day, and year) February 25-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm. H. Schubert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Edith Hyatt 140 Collins Ave

15 Filed DEC 22 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Dec 21, 1920, that I last saw h— alive on Dec 20, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cof, M. D.

Dec 22 1920 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 24 1920
20 UNDERTAKER	ADDRESS
H B Kuppert	2236 Fredk Ave

TION is very important. See instructions

D 49164

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 D 49164

PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 116 S Stockton St. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Johnson

(Residence in Baltimore: No. 116 S Stockton St.: 3 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fmd.

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Sing.

6-DATE OF BIRTH: Oct. (Month) , 1917 (Year)

7-AGE: 3 yrs. 2 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Wm. Johnson

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Fanny Johnson

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard A Chaney

(Address) 116 S Stockton

15- Filed DEC 23 1920 ROBERT B KRAUTER Clerk
Burial Permit Issued
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 22 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1920, to Dec. 22, 1920, that I saw h- alive on Dec. 22, 1920, and that death occurred, on the date stated above, at 5.50 P. m.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Cachexia Dyspepsia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), H. Howard Keech M. D.

Dec. 22, 1920 (Address) 219 N. Collins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Gilead Md. DATE OF BURIAL: 12/23, 1920

20-UNDERTAKER: Edw B Hale ADDRESS: N5 E Mon St

N. B.-Every item of information that it may be properly entered state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49165

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Coccoristine

(a) RESIDENCE. No. 117 E Lexington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) pod

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos Coccoristine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Goffredo

13 BIRTBPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record
(Address) J. H. H.

15 [illegible] DEC 23 1920 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Dec 22 — 1920, that I last saw h[illegible] alive on Dec 22 — 1920, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Fop, Jr, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	December 23 1920
20 UNDERTAKER	ADDRESS
Wendell Raffel & Son	378 Aisquith St

CAUSE OF DEATH to be written in plain English. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049166 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049166

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elmira Virginia Sales

(a) RESIDENCE. No. 1819 Eagle ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. A. Sales

6 DATE OF BIRTH (month, day, and year): June 23 - 1846

7 AGE: Years 74 Months 5 Days 29 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Chas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Troxel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Chas Sales

(Address) 1819 Eagle St.

15 [illegible] DEC 23 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-20, 1920, to 12-21, 1920, that I last saw her alive on 12-21, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. McCraig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 23 1920

20 UNDERTAKER: George L Schwartz & Bro — ADDRESS: 2101 Eutaw Ave

CAUSE OF DEATH in plain words. Do not use abbreviations or initials. Name of disease alone not sufficient. Omissions will delay registration. Be sure to fill out every item. Information is required by law. Physician must sign certificate. Undertaker must file certificate with Registrar. Burial Permit will not be issued unless certificate is properly filled out. See instructions on back of certificate. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

049167 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 049167

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 E. Lafayette Ave. 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Rudsell Sears

(a) RESIDENCE. No. 421 E. Lafayette Ave 12th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 88 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Cyrus Sears

6 DATE OF BIRTH (month, day, and year) June 18, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Yarmouth, Mass. U.S.A.

PARENTS

10 NAME OF FATHER Sylvester Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Sabra Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.A.

14 Informant (Address) Gus W. Dohme M.D. 3014 St. Paul St.

15 DEC 23 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21st 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 1920, to Dec. 21st, 1920, that I last saw her alive on Dec. 21st, 1920, and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Over

Cerebral Endarteritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Femur

(duration) 0 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

12/21/1920 (Address) 3014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 23 1920

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 N. Fayette

CAUSE OF DEATH must be stated on back of certificate. See instructions on back of certificate. ATTENTION is very important.

...STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fill in room.

049168 HEALTH DEPARTMENT---CITY OF BALTIMORE 049168

CERTIFICATE OF DEATH

120

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1217 Bolton ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Fitch Kleinfelter

(Residence in Baltimore: No. 1217 Bolton St.; 79 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: December 22, 1840 (Month) (Day) (Year)

7-AGE: 79 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto, Md

PARENTS

10-NAME OF FATHER: Henry Kleinfelter

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Fitch

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ella K. Folsom
per Charles Getz, M.D.

(Address) 6113 W. Lanvale St

15- DEC 23 1920 Filed ....., 191 ROBERT J KRAUTER Burial Permit Clerk REGISTRAR

N. B.—Every CAUSE OF DEATH must be plainly stated. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1920, to, Dec. 23 1920, that I saw him alive on Dec. 21 1920, and that death occurred, on the date stated above, at 6.06 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) unknown yrs. mos. ds.

Contributory (SECONDARY) Arteriosclerosis

(Duration) unknown yrs. mos. ds.

(Signed), Charles Getz M. D.

Dec. 22, 1920 [Address] 6111 W. Lanvale St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Green Mount Cem. DATE OF BURIAL: Dec 24, 1920

20-UNDERTAKER: John O. Mitchell ADDRESS: 1701 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

049169 HEALTH DEPARTMENT—CITY OF BALTIMORE 049169

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Wyman Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Tierney

(a) RESIDENCE. NO. 201 Wyman Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Frank Tierney.

6 DATE OF BIRTH (month, day, and year) Dec. 25-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Gracie McFee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Frank E. Ballantyne
(Address) Hampton Court Apts

15 Filed DEC 23 1920 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21- 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to Dec 21, 1920, that I last saw h... alive on Dec 21 1920, and that death occurred, on the date stated above, at 9 38 A m.

The CAUSE OF DEATH* was as follows:

E Pneumonia

(duration) 1 wk. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) needs yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests & Symptoms

(Signed) Catherine [illegible] M. D.

Dec 23, 1920 (Address) 1124 N. 20 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec. 24 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

CAUSE OF DEATH ... TION is very important. See instructions on back

1049170 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049170

CERTIFICATE OF DEATH.

64

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 604 S. Broadway ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Henry Boud St

(Residence in Baltimore: No. 604 S. ~~Broadway~~ Boud St St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1848
(Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Cook 040

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Lotterweck

(Address) 604 S. Broadway

15- DEC 23 1920 ROBERT E KRAUTER
Filed ....., 191.... Burial Permit Clerk
Registrar.

CAUSE OF DEATH in plain terms. If uncertain, say so. Do not state mode of dying, but the disease causing death. Name the disease causing death, not merely a symptom of disease. Do not use abbreviations or initials. If from accident, violence, or casualty, state the nature. If from any dangerous or insanitary occupation, state the same. If a woman, state whether death was in any way connected with pregnancy or childbirth. If from infectious disease, state whether case was reported to Health Department. If not, why not? This information is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22nd, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... days

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Bonny Lyon Pilgrim M. D.
(Coroner)

12/22, 1920. (Address) 1800 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cemetery	Dec. 23rd, 1920
20-UNDERTAKER Lilly-Zeiler	ADDRESS 403 S. Wolfe St

H 1433

44917 / HEALTH DEPARTMENT—CITY OF BALTIMORE / 44917

160

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1 East of Ann St. ST.: 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Isaac Goldman
(Residence in Baltimore: No. 250 S. Caroline st ST.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 45 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country). Russia
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lewis
(Address) 1411 E Baltst

15-Filed DEC 23 1920, 191.. ROBERT P KRAUTER Registrar. Burial Permit Clerk

N. B.—Everything in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide by Cutting throat with Razor
(Duration).....yrs.....mos.....ds.
CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.
(Signed) [illegible] M. D.
Dec 22 1920 (Coroner.) (Address) 2004 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Sinai
DATE OF BURIAL, Dec 23, 1920
20-UNDERTAKER Jack Lewis
ADDRESS 1411 E. Balt

Spec.—8-24-14—M. & T.—2000 Bks.

049172

HEALTH DEPARTMENT—CITY OF BALTIMORE

049172

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH University Hospital

REGISTERED No. C

CITY OF BALTIMORE: (No. Lombard & Green ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lina Lucas

(Residence in Baltimore: No. 520 S Rose St. Aft. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, [illegible], 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Molde (Unknown)

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Lucas

(Address) 520 S Rose St

15- DEC 23 1920 ROBERT J KRAUTER

Filed ....., 191... Burial Permit Clerk.
Registrar.

CAUSE OF DEATH. See instructions on back of certificate. Information important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 13 1920, to December 22 1920, that I saw h-d alive on December 22 1920, and that death occurred, on the date stated above, at 4:50 p m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Hundley Jr. M. D.

, 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Immanuel Cemetery

DATE OF BURIAL, Dec 24, 191.20

20-UNDERTAKER Louis Heermann

ADDRESS 326 Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

2049173 HEALTH DEPARTMENT—CITY OF BALTIMORE 2049173

CERTIFICATE OF DEATH. X 10-079

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 622 Hanover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ira W. Carneana

(a) RESIDENCE. NO. 622 Hanover ST., WARD Seaford Del.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie E Carneana

6 DATE OF BIRTH (month, day, and year) Sept 18 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saw & Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Co 040

(c) Name of employer Amanda Co

9 BIRTHPLACE (city or town) (State or country) Seaford Del

PARENTS

10 NAME OF FATHER Geo E Carneana

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harfstown MD

12 MAIDEN NAME OF MOTHER Linda Hearn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Seaford Del

14 Informant (Address) Mrs Addie E. Carneana 622 Hanover st

15 DEC 23 1920 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/7, 1920, to 12/21, 1920, that I last saw h... alive on 12/21, 1920, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Whitelo M.D., M. D.

12/23, 1920 (Address) 1179 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Seaford Del. Bl'k a.

DATE OF BURIAL Dec 23 1920

20 UNDERTAKER John A Denny

ADDRESS 715 Lynch St

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049174 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) N.E. Home for Aged ... Franklin St. (Ward) 20 Fulton 29

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hildebrandt

(a) RESIDENCE. No. Home for Aged ... ST., ... WARD. ...
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July-13-859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John Hildebrandt

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Sara Parlett

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Mrs. Ella Cuddy Sister
(Address) N.E. Home for Aged Fulton & Franklin Sts

15 DEC 23 1920 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.-22- 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov-1- 1920, to Dec-22 1920, that I last saw her alive on Dec.-19- 1920, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile dementia with
Chronic Myocarditis,
Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

Dec 23, 1920 (Address) 2702 Garrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. E. Cloud	Dec 24, 1920
20 UNDERTAKER George J. Smith	ADDRESS 2900 Foyate St

CAUSE OF DEATH to be filled in plainly with ink or indelibly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Pks.

049175 HEALTH DEPARTMENT—CITY OF BALTIMORE 049175

CERTIFICATE OF DEATH. X 45

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Robert Page

(a) RESIDENCE. NO. Belair ST., WARD. Belair, Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Robert Page

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Dr. Randolph Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Frances M Page (Address) 1327 Bolton St

15 Filed DEC 23 1920 Robert B Reuter Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22nd 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1920, to Dec 22, 1920, that I last saw h~~im~~ alive on Dec. 22nd, 1920, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Complete block of ureters, with anuria (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Sept 27th, 1920

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation + autopsy.

(Signed) J. W. Kinnaman, M. D.

Dec 22, 1920 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Spring Cem. Belair Md.	12-24-1920
20 UNDERTAKER	ADDRESS
Henry W Kuhlmann & Sons Co	W Fallsway Orchard

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Mariah Stevens

049176 HEALTH DEPARTMENT—CITY OF BALTIMORE 049176

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1524 Eutaw St.: 7 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mariah Stevens

(Residence in Baltimore: No. 1524 Eutaw St. (yrs., 1) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	col.	Widow

6-DATE OF BIRTH, ..., 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Lewis Kelem

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lucy Collins

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Toy

(Address) 1524 E. Madison st

15- DEC 23 1920 ROBERT E KRAUTER
Filed ....., 191.... Registrar.
Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Eastville Station Va	Dec 24th 1920
20-UNDERTAKER	ADDRESS
Thos L Bailey	442 Jefferson st

CAUSE OF DEATH in plain terms. It is important. See instructions on back of certificate.

1049177 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049177

Supplementary

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 565 Moore St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Elizabeth Flowney

(Residence in Baltimore: No. 565 Moore St. St.; yrs., mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, Dec. 9, 1920
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (Infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Melvin Barclay Flowney

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Margaret Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin B. Flowney

(Address) 565 Moore St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Gas

(Duration) ....yrs....mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. D. Neumeyer M. D.
(Coroner.)

Dec. 24 1920 (Address) 1811 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

N.B.—Every question must be answered. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Coroner's Certificate)

D 49177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 491

REGISTERED NO.....

(If death oc
a hospital or
tion, give its
instead of st
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 565 Monroe St. 17 WARD)

2-FULL NAME Louisa Elizabeth Flowney

(a) RESIDENCE. No. 565 Monroe St., ST., WARD.
(Usual place of abode)
(If nonresident give city or town and

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Melvin Beulah Flowney

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pekin, ?

11 Informant M. B. Flowney

(Address) 565 Monroe St

15 Filed DEC 23 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21

17 I HEREBY CERTIFY, That I attended decea
....., 19....., to.....,
that I last saw h.....alive on.....,
and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

Patient Frances O

(duration) yrs. mos. 1

CONTRIBUTORY (Secondary)
(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hennessy M.D.
Dec 22, 19 20 (Address) 2802 Edmondson a

*State the Disease Causing Death, or in deaths from Violent Ca
state (1) Means and Nature of Injury, and (2) whether Accide
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BU
Dr A auburn ce	Dec 2
20 UNDERTAKER David Earlam	ADDRESS E 16 St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49178

CERTIFICATE OF DEATH.

1920 D 49178

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1927 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys [redacted] Johnson

(a) RESIDENCE. NO. 1927 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Md 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Housewife

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Samuel J. Parmer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachael Rodgers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Daniel Easter
(Address) 1926 Pa Ave

15 Filed DEC 23 1920 ROBERT F. TRAUTH Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 and 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16th, 1920, to Dec 22 and 1920, that I last saw h[illegible] alive on Dec 21st, 1920, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Chronic

(duration) yrs. 1 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Acute Pneumonia Labor

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Geo. H. Lautenbach, M. D.

Dec 22, 1920 (Address) 2218 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 26 1920
20 UNDERTAKER Daniel Easter	ADDRESS 926 Calhoun

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49179

D 49179

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Temple ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Jane

(a) RESIDENCE. NO. 4 Temple ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Jane

6 DATE OF BIRTH (month, day, and year) Unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Va

14 Informant John Jane Jr.
(Address) 1623 McCulloh St.

15 Filed DEC 23 1920 19 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Dec. 21, 1920, that I last saw h[illegible] alive on Dec. 21, 1920, and that death occurred, on the date stated above, at 2-20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt. J. Green, M. D.

12-22-1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 24 1920
20 UNDERTAKER	ADDRESS 916
Daniel Eardley	Penn

CAUSE OF DEATH to be plainly written. Use ink. Do not use lead pencil. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049180 HEALTH DEPARTMENT—CITY OF BALTIMORE 049180

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH
CITY OF BALTIMORE (NO. St Joseph Hospital ST. 22 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Guzauskis

(a) RESIDENCE. NO. 636 S. Paca ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S.

5 If married, widowed, or divorced HUSBAND of (or) WIFE of July 29- 1912

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8.	7	4	22

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Stane Guzauskas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Veronika Aleknavecute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Stanislaus Guzauskis
(Address) 636 S Paca St

15 Filed ... 19 ... ROBERT B KRAUTHS Registrar
DEC 23 1920 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1920, to Dec 21, 1920, that I last saw her alive on Dec 21st, 1920, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffi
Lasting about (duration) 4 days

CONTRIBUTORY (Secondary) Acute Osteomyelitis about (duration) 3 weeks 8 mos. ds.

18 Where was disease contracted if not at place of death? Yes Date of Dec 11.

Did an operation precede death? No.

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. M. Schmauch M. D.

19 (Address) St Josephs Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 12/24/1920

20 UNDERTAKER John Grebiancka ADDRESS 425 S. Paca St

CAUSE OF DEATH ... See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149181 HEALTH DEPARTMENT—CITY OF BALTIMORE 149181

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 4332 N. Charles St.; 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter Lord

(a) RESIDENCE. No. 4332 N Charles St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~: Henrietta M. Lord

6 DATE OF BIRTH (month, day, and year): July 4th 1875

7 AGE: Years 64; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which ~~employed (or employer)~~:

(c) Name of employer: John R Ford

9 BIRTHPLACE (city or town) (State or country): St Louis Mo.

PARENTS

10 NAME OF FATHER: C. R Lord

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: F. E. Walterhouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: L. Lee Hoffman Jr
(Address) Stevens Md.

15 Filed DEC 23 1920 ROBERT I. KRAUSE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22nd 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1912, to Dec 22nd, 1920, that I last saw h.. alive on Dec 22nd, 1920, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
with Hypertension

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Edema of Lungs
Pneumonitis (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure - Urine - Blood

(Signed) Gordon Burbridge M. D.

Dec 22 1920 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 24 19 20
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Son	Orchard &

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

John Naparstek.

049182 HEALTH DEPARTMENT—CITY OF BALTIMORE 049182

CERTIFICATE OF DEATH.

91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Thames ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Naparstek

(a) RESIDENCE. No. 1524 Thames ST., 3 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Veronika Naparstek

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Clay Laborer

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Martin Naparstek.
(Address) 1804 Alabama Ave

15 Filed DEC 23 1920 Burial Permit Issued

CAUSE OF DEATH. See instructions on back of this sheet. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1920

17

I HEREBY CERTIFY, That I attended deceased from 12-12, 1920, to Dec 21, 1920, that I last saw h[illegible] alive on Dec 21, 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis, & Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Jos D Butbsh, M. D.

12-22-19 (Address) 1622 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Dec 24 1920

20 UNDERTAKER M. F. Sadowski ADDRESS 905 S. Ann

Spec. 6-9-19 H. P. Co.—1000 Bks.

049183 HEALTH DEPARTMENT—CITY OF BALTIMORE 049183

CERTIFICATE OF DEATH.

91-081

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 4c WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Giest

(a) RESIDENCE. NO. 125 S. Ellwood Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed DEC 23 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 4, 1920, to December 22, 1920 that I last saw him alive on December 21, 1920, and that death occurred, on the date stated above, at 12:40 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) W H Ernman, M. D.

12/22/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Dec 24 1920

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 405 S. Wolfe St.

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49184 HEALTH DEPARTMENT—CITY OF BALTIMORE L49184

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 W. Lexington St. St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Hook

(a) RESIDENCE. No. 1721 W. Lexington St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine A. Hook

6 DATE OF BIRTH (month, day, and year) Oct. 31 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millwright 007

(b) General nature of industry, business, or establishment in which employed (or employer) B and O.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John T. Hook

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emeline Ritter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Catherine A. Hook
(Address) 1731 W. Lexington St.

15 Filed DEC 23 1920 ROBERT J. KRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23rd 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Dec 23 1920, that I last saw h. m. alive on Dec 21 1920, and that death occurred, on the date stated above, at 10.40 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorica

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Drew Hemmeter M. D.

12-23 1920 (Address) 800 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 24 1920
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Pratt St.

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

049185 HEALTH DEPARTMENT—CITY OF BALTIMORE 049185

CERTIFICATE OF DEATH.

168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 Hollins ST.: 19 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander D. Campbell

(Residence in Baltimore: No. 1606 Hollins St.: (yrs., 29 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Feb (Month) 14 (Day), 1891 (Year)

7-AGE, 29 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter A.H.
(b) General nature of industry, business, or establishment in which employed (or employer) Jobber

9-BIRTHPLACE, (State or Country). Canada

PARENTS.

10-NAME OF FATHER. Campbell

11-BIRTHPLACE OF FATHER (State or Country). Scotland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irvin Campbell

(Address) 2409 Arunah ave

15- Filed DEC 23 1920, 191... ROBERT P. KRAUTH Burial Permit Clerk Registrar.

N. B.—Every item should be answered in ink or typewritten, so that if any be illegible or illegibly written it may be returned for correction. CAUSE OF DEATH in plain terms, so that it may be correctly classified. Underlining or abbreviations should be avoided. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Accident

(Duration) few hrs. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Benton M. D. (Coroner.)

Dec. 22 1920 (Address) 700 Clarence

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 22, 1920
20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49186 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49186

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 d 3 N Robinson ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Speyer

(a) RESIDENCE. No. 3 d 3 N. Robinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years | Months | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Augustus Speyer

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Md

12 MAIDEN NAME OF MOTHER Hazel T. Dickey 12-23-1920

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant Mrs. Hazel Speyer (Address) 3 d 3 N. Robinson

15 Filed DEC 23 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1920, to Dec 22, 1920, that I last saw h[illegible] alive on Dec 21, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 8 m. Month

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F L Pinard, M. D.

12-23-1920 Address 3 d 3 N Robinson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery | DATE OF BURIAL Dec 23 1920

20 UNDERTAKER [illegible] | ADDRESS [illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49187

CERTIFICATE OF DEATH.

64-

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3641 Chestnut Ave (WARD) 13

2-FULL NAME Eliza J Reaver

(a) RESIDENCE. NO. 3641 Chestnut Ave WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Reaver

6 DATE OF BIRTH (month, day, and year) Aug 21 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Trump

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Magie Shoemaker (Address) 3644 Chestnut Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

DEC 23 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1918, to Dec 18, 1920

that I last saw h.. alive on Dec 22, 1920

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Chemical & Mic.

(Signed) C. R. Wantz, M. D.

Dec 23 1920 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 24 1920

20 UNDERTAKER Chenowith Son ADDRESS Chestnut Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49188 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49188

CERTIFICATE OF DEATH. X 105

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Clifton.

(a) RESIDENCE. NO. Faison. N. C. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of T. T. Clifton.

6 DATE OF BIRTH (month, day, and year) Jan. 30. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0 3

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sampson Co. N.C.

PARENTS

10 NAME OF FATHER Robert Drew.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nancy Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~North Carolina~~

14 Informant Hospital Record

(Address) ~~Mercy Hospital~~ Robert T. Higgins, Registrar

15 DEC 23 1920. 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 19 20

17

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 19 20, to Dec. 22, 19 20, that I last saw h[illegible] alive on Dec. 22, 19 20, and that death occurred, on the date stated above, at 6.15 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Duodenal Ulcer.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia; acute dilatation of Stom. (duration) yrs. 3 days.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec. 20 20

Was there an autopsy? No.

What test confirmed diagnosis? Laparotomy.

(Signed) O. J. Sebastian M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Faison N C	12/23/20
20 UNDERTAKER Geo. A Farley Sutton & Snyder	ADDRESS

CAUSE OF DEATH must be given by physician on back of certificate. ATTENTION is very important. See instructions on back of certificates.

Kuzmicki

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49189 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49189

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 S. Ouston ST.; W WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kuczynski

(a) RESIDENCE. No. 512 S Ouston ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Dec. 23 1920

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Felix Kuczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Borskouska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Felix Kuczynski

(Address) 512 S. Ouston St.

15 DEC 23 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Dec 23, 1920,

that I last saw h... alive on ....., 19....,

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. J. Russell, M. D.

12/27/20, 19 (Address) 801 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 23 1920

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank

Spec.—6-9-13—H. P. Co.—1000 Bks.

D.49190 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49190

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Nephew

(a) RESIDENCE. No. Unknown St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Interment Hospital Records, New City Hospital.
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21, 19 20

17 I HEREBY CERTIFY, That I attended deceased from December 20, 19 20. to December 21 19 20.
that I last saw h er alive on December 21, 1920,
and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis
(no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuf-
ficiency (duration) yrs. mos. 10 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) B Heaman M. D.

12/21/1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 23 1920

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it can be understood by persons not familiar with technical terms of certificates. See instructions on back of certificate. TION is very important.

98

17701

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49191 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49191

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N Carrollton ST.; 16 WARD)

2-FULL NAME Alice Edna Hull

(a) RESIDENCE. No. 604 N Carrollton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J Hull

6 DATE OF BIRTH (month, day, and year): Aug 31 1875

7 AGE — Years: 45 — Months: 3 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Cyrus N. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ida E Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Chas J Hull

(Address) 604 N Carrollton

15 Filed DEC 23 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar 16 1915, to Dec 23 1920, that I last saw h alive on Dec 22 1920, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Abrance Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Hypertrophy & Dilatation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J. M. Lumpkin, M. D.

Dec. 23 1920 (Address) 426 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 27 1920

20 UNDERTAKER: D J Gutschlon & Son — ADDRESS: Harlem

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49192

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugo Gahn

(a) RESIDENCE. NO. Pushtuny Md ST. WARD.
(Usual place of abode) Baltimore Road & opp Montrose
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE: 55 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 086
(b) General nature of industry, business, or establishment in which employed (or employer): Farm
(c) Name of employer Wm Berger

9 BIRTHPLACE (city or town) (State or country): Unknown Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant Wm Berger
(Address) Pushtuny Md

15 [illegible] 19

Robert P. Harrison,
Registrar
Burial Permit Clerk.

DEC 23 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21/1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 21, 1920, that I last saw him alive on Dec 21, 1920, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Sputum

(Signed) Chas - A Demorgan, M. D.

, 19 (Address) 6 - E Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Dec 24 19 20
20 UNDERTAKER	ADDRESS
Fredk Lazenby & Son	Fullerton

mation should be entered, if known, in each space, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49193 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49193

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1320 Reynold St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria J. Lonczynska

(a) RESIDENCE. No. 1320 Reynold ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) Oct. 9-1920

7 AGE — Years: — Months: 2 Days: 14 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Joseph Lonczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland,

12 MAIDEN NAME OF MOTHER Mary Pietszak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore,

14 Informant Joseph Lonczynski
(Address)

15 Filed ..., 19.. Robert P. Harrison, Registrar

DEC 23 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-1920

17 I HEREBY CERTIFY, That I attended deceased from 12-18-, 1920, to 12-23-, 1920, that I last saw h.. alive on 12-22-, 1920, and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis, febrinous.

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Premature birth.

(duration) ... yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Ingmar Pirath, M. D.

12-23-1920 (Address) 2200 N. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary. DATE OF BURIAL: Dec 24 1920

20 UNDERTAKER: Gallowich 1618 ADDRESS: Eastern Ave.

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

049194 HEALTH DEPARTMENT—CITY OF BALTIMORE 049194

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4024 Bell Avenue 15th Eighth WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Clark

(a) RESIDENCE. No. 4024 Bell Av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 5yr yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Louise Clark

6 DATE OF BIRTH (month, day, and year) 5 March 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing / old

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bacto City

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Emma L Clark

(Address) 4024 Bell Ave

15 Filed DEC 23 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Dec 22, 1920, that I last saw him alive on Dec 22, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis and nephritis

Some (duration) 12 yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Emphysema & Exhaustion

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exam.

(Signed) Robert W. Moffett, M. D.

, 19 (Address) No 1016 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 24 1920

20 UNDERTAKER Dorsch Syfer 1600 N North ave ADDRESS

TION is very important. See instructions on back of

D49195 — HEALTH DEPARTMENT--CITY OF BALTIMORE — D49195

CERTIFICATE OF DEATH

1 PLACE OF DEATH

28 REGISTERED NO. C

CITY OF BALTIMORE (No. 2808 Parkwood Ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Gerecken

(Residence in Baltimore: No. 2808 Parkwood Ave St.; Lft yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct 3, 1879 (Month) (Day) (Year)

7 AGE: 41 yrs. 2 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: J. W. Hoddnott

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza J. Burton

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Gerecken

(Address) 2808 Parkwood Ave

15. DEC 23 1920, 191 ROBERT B KRAUTER Burial Permit Registrar

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 23, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920 to Dec 23 1920, that I saw h[illegible] alive on Dec 22, 1920, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) S. Osmund Garth M. D.

Dec 23, 1920 (Address) 2731 Parkway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore — DATE OF BURIAL: Dec 25, 1920

20 UNDERTAKER: Josiah Leffler — ADDRESS: 1600 N North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

b 49196

HEALTH DEPARTMENT—CITY OF BALTIMORE

b 49196

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. St. Josephs Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes B. Scally

(a) RESIDENCE. No. 1108 Wilcox ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Scally

6 DATE OF BIRTH (month, day, and year) November 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Coogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mrs. Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr John F Scally

(Address) 1108 Wilcox St

15 DEC 24 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Dec 23, 1920.

that I last saw her alive on Dec 23, 1920,

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocordeal Insufficiency

Interval (duration) days yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbuncle

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hpr Date of Dec 23

Did an operation precede death? Hpr Date of Dec 23

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J A Schumacher M. D.

19 (Address) St Josephs Hosp. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 27 1920
20 UNDERTAKER Henry Hooch Son	ADDRESS 1301 E Eager St

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

049197 HEALTH DEPARTMENT—CITY OF BALTIMORE 049197

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62 Roland Court ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Fox

(a) RESIDENCE. No. 62 Roland Court ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Fox

6 DATE OF BIRTH (month, day, and year) Oct 31-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John A. Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Hannah Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mrs. Charles Cross (Address) 62 Roland Court

15 Filed DEC 24 1920 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24th, 1920, to Dec. 23rd, 1920, that I last saw her alive on Dec. 23rd, 1920, and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Johns, M. D.

12/23/1920 (Address) 3014 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 24 '20

20 UNDERTAKER H. E. Hughes ADDRESS 4324 W. Broadway

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49198 HEALTH DEPARTMENT—CITY OF BALTIMORE D49198

CERTIFICATE OF DEATH. 92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Casurel Hotel, Balto & Hanover Sts WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Rindell

(a) RESIDENCE. NO. Newark N. J' ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice C. Rindell

6 DATE OF BIRTH (month, day, and year) Oct 16-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Anthony R. Rindell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Mary E. Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. York

14 Informant Alice C. Rindell
(Address) 15 Midland Ave Kenilworth N.J.

15 Date DEC 24 1920 ROBERT J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 23, 1920, that I last saw him alive on Dec 23, 1920, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W R Gormley, M. D.

12-24 1920 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark N. J'	12-24 1920
20 UNDERTAKER	ADDRESS
John A Mitchell	1201 W Fayette St

TION is very important. See instructions on back of

...—6-9-19—H. P. Co.—1000 Bks.

1049199 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049199

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3722 Foster Ave ST. Balto WARD 10

2-FULL NAME Wisthen E. Hewes Offz

(a) RESIDENCE. NO. 3722 Foster Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Widower

DATE OF BIRTH (month, day, and year) April 8 1849

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	14	

7 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman 886
(b) General nature of Industry, business, or establishment in which employed (or employer) Hide & Tallow
(c) Name of employer Same

8 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest Hary Hdwy
(Address) 4602 Gus Ave Balto

15 Filed DEC 24 1920 19 ROBERT P. BEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920 to Dec 22, 1920

that I last saw him alive on Dec. 21, 1920

and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

X (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Stated

Did an operation precede death? X Date of

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Wm E Swan, M. D.

19 (Address) 2458 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL Dec 24 1920

20 UNDERTAKER John Herwig & Co

ADDRESS 4608 Aleana

Spec. 6-9-19—H. P. Co.—1000 Bks.

D49200 HEALTH DEPARTMENT—CITY OF BALTIMORE D49200

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Lindeman

(a) RESIDENCE. NO. 2101 E. Madison St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Unknown~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Unknown~~ 017

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar maker

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Unknown~~ Ky.

(State or country)

PARENTS

10 NAME OF FATHER John Lindeman

11 BIRTHPLACE OF FATHER (city or town) ~~Unknown~~

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ~~Unknown~~

(State or country) Germany

14

Informant Hospital Records,

(Address) New City Hospital.

15 Filed DEC 24 1920 ROBERT F. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from November 24, 1920, to December 23 1920, that I last saw him alive on December 22, 1920, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(Cerebral Hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) J. H. Herman, M. D.

12/23/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 25 1920
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

6-9-19—H. P. Co.—1000 Bks.

49201 HEALTH DEPARTMENT—CITY OF BALTIMORE X49201

CERTIFICATE OF DEATH.

29

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No.) 3614 Elm Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Catharine McClain.

a) RESIDENCE. NO. 3614 Elm Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

gth of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

married, widowed, or divorced
HUSBAND of (or) WIFE of William McClain

TE OF BIRTH (month, day, and year) Aug 14 1842

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Retired

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Benjamin Noel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Sisk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Mary McClain
(Address) 3614 Elm Ave

Filed DEC 24 1920 ROBERT [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from December 6th, 1920, to December 23rd, 1920, that I last saw her alive on December 23rd, 1920, and that death occurred, on the date stated above, at 340 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis et
arteriosclerosis

(duration) 1 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Clopton, M. D.

, 19 (Address) 2919 Huntingdon Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Govans	Dec 24 1920
20 UNDERTAKER	ADDRESS
Chenowith Son	Chestnut Ave

c.—6-9-19—H. P. Co.—1000 Bks.

049202

HEALTH DEPARTMENT—CITY OF BALTIMORE

049202

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No 3976 Elm Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Batchlor

(a) RESIDENCE. No. 3976 Elm Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Batchlor

6 DATE OF BIRTH (month, day, and year) Feb 16 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Ella Batchlor
(Address) 3976 Elm Ave

15 Filed DEC 24 1920 ROBERT J [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Dec 24, 1920, that I last saw h[illegible] alive on Dec 23, 1920, and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis - Central Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry E. Algire M. D.

(Address) 3740 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Dec 27 1920

20 UNDERTAKER Chenowith Son

ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1600 Bks.

D49203 HEALTH DEPARTMENT—CITY OF BALTIMORE D49203

CERTIFICATE OF DEATH. 15

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1356 N. Stricker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edword Washington

(a) RESIDENCE. NO. 1356 N Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1356 Stricker St Baltimore Md

PARENTS

10 NAME OF FATHER Edword Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Estella Stepney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Estella Washington (Address) 1356 Stricker St

15 Filed DEC 24 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1920, to Dec 21, 1920, that I last saw h alive on Dec 20, 1920, and that death occurred, on the date stated above, at 12 10 m.

The CAUSE OF DEATH* was as follows:

Premature Birth due Feb. 1921.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H Wright, M. D.

Dec 21, 1920 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 28 1920
20 UNDERTAKER	ADDRESS
Edward Cuggold	1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be understood by clerks of certificates. TION is very important. See instructions on back of

Willie R. Hemingway

D49204 HEALTH DEPARTMENT—CITY OF BALTIMORE D49204

CERTIFICATE OF DEATH.

REGISTERED No. C 4 92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 707 Redwood St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie R. Hemingway

(Residence in Baltimore: No. 707 Redwood St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Feb 6, 1913 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
6 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Nathaniel Hemingway

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Carie Bryant

13-BIRTHPLACE OF MOTHER (State or Country), Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathaniel Hemingway

(Address) 707 Redwood St.

15- ROBERT P. KRAUTER

Filed DEC 24 1920 191... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D. (Coroner.)

12-23, 1920 (Address) 117 N. Sanbya

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	DEC 24 1920
20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049205 ~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~ 1049205

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 S Paca ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Eisenstein

(a) RESIDENCE. NO. 842 S. Paca ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Eisenstein

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) cigars

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unkown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Baltimore St

15 DEC 24 1920 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Dec. 22, 1920, that I last saw him alive on Dec. 19, 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Dillett, M. D.

12/23 1920 (Address) 621 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrenbach Road	12/24 1920
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 Eldon

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

049206 HEALTH DEPARTMENT—CITY OF BALTIMORE 049206

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 West North Ave. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Boring

(a) RESIDENCE. No. 726 West North Ave 13th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or WIFE) of~~ wife John H. Boring

6 DATE OF BIRTH (month, day, and year) Oct 1st 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	68	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~housewife~~ 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles ~~H~~ Schier

11 BIRTHPLACE OF FATHER (city or town) Bremen (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Eck

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant John H. Boring

(Address) 726 West North Ave

15 DEC 24 1920 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Dec. 22, 1920, that I last saw h.. alive on Dec. 22, 1920, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 37 ds.

CONTRIBUTORY (Secondary) Arteri-sclerosis

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marvin Lazenby, M. D.

12/22 1920 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 24 1920

20 UNDERTAKER Fred A. Krause ADDRESS Boston

CAUSE OF DEATH in plain terms. Omit all technical terms. Name contagious diseases. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2049207

HEALTH DEPARTMENT—CITY OF BALTIMORE

2049207

CERTIFICATE OF DEATH.

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 Foster Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georg & Emil Commyns

(a) RESIDENCE. NO. 3906 Foster Ave ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH to plain terms, avoiding use of technical terms. Use reverse side for additional space. Statement of contributory causes of death is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Emil Commyns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belgium

12 MAIDEN NAME OF MOTHER Frances Sanutti

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy Md.

14 Informant: Frances Commyns
(Address) 3906 Foster Ave

15 Filed DEC 24 1920 ROBERT B [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec 22, 1920, that I last saw him alive on Dec 22, 1920, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Sty postaglen Pneumonia & Partus ? Cholecystitis Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Waller, M. D.

12/24/1920 (Address) 3353 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 24 1920

20 UNDERTAKER: Fitzgerald

ADDRESS: 4038 Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

6 49208 HEALTH DEPARTMENT—CITY OF BALTIMORE 6049208

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Spruce alley ST.: 2 WARD)

2-FULL NAME Maryanna Koterwas

(a) RESIDENCE. NO. 2002 Spruce alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wianty Koterwas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Blusiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wicenty Koterwas
(Address) 2002 Spruce alley

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 20

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 19 20, to Dec 23, 19 20, that I last saw h[illegible] alive on Dec 23, 19 20, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J Wenderowicz, M. D.

19 (Address) 1102 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 24 1920

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

D 49209 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49209

CERTIFICATE OF DEATH. 151

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4719 E Lombard St. ST.; 26 WARD)

2-FULL NAME Baby Hoffman

(Residence in Baltimore: No. 4719 E Lombard St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Dec 21 ....., 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Ind.

12-MAIDEN NAME OF MOTHER Grace E Peacock

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Peacock

(Address) 4219 E. Fairfield

15- DEC 24 1920 ROBERT A KRAUTER
Filed ....., 191.... Registrar.

N. B.—Every item of information called for in this CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 22 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Investigation find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Kinsella M. D.
(Coroner.)

Dec 24, 1920 (Address) 1800 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int Old Cathedral — DATE OF BURIAL, 12-24-20

20-UNDERTAKER J. G. Moran — ADDRESS 3000 Eastern Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

W49210 HEALTH DEPARTMENT—CITY OF BALTIMORE 152 W49210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N Ostend ST.: 21 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Florence Garrett

(a) RESIDENCE. No. 809 N Ostend ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 20, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			#3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Garrett

11 BIRTHPLACE OF FATHER (city or town) Shipley
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Hammond

13 BIRTHPLACE OF MOTHER (city or town) Shipley
(State or country) Maryland

14 Informant Daniel Easter
(Address) 916 Pa ave

15 DEC 24 1920

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 23, 1920, that I last saw her alive on Dec 22 1920, and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:

Accidental Hemorrage from umbilical cord.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morris Reed, M. D.

12-23-20, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 24 1920
20 UNDERTAKER Daniel Easter	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that a layman can understand it. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49211

CERTIFICATE OF DEATH.

79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 Allendale ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Startzman

(a) RESIDENCE. No. 2506 Allendale ST., WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? 78 yrs. 11 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Startzman

6 DATE OF BIRTH (month, day, and year): July-5-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harrisburg Penna

12 MAIDEN NAME OF MOTHER: Sarah Groves

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mr. Wallis T. Startzman (Son)

(Address): 111 Woodlawn Road

15 DEC 24 1920, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH to be filled in by physician. Information on back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1920, to Dec. 21st, 1920, that I last saw her alive on Dec. 21st, 1920 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

16 days (duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Diagnosis of Dr. Thatcher

(Signed) Nellie V. Mark, M. D.

19 (Address) 1318 Leinden Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Dec 24 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1181 N. Calhoun St

D.49212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49212

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Smallwood ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Lewis Stephens

(a) RESIDENCE. NO. 320 S. Smallwood ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Susanna Stephens

6 DATE OF BIRTH (month, day, and year) Nov 30-1843

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77	—	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James H. Stephens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza Loy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md

14 Informant James H. Stephens
(Address) 320 S. Smallwood

15 Filed ..., Robert F. Harrison, Registrar
Burial Permit Clerk.

DEC 24 1920

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Dec 23, 1920, that I last saw him alive on Dec 22, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. G. Smith, M. D.

Dec 24, 1920 (Address) 1182 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 25/20

20 UNDERTAKER — ADDRESS

K B Hesselbrock 2236 Frederick

D.49213 HEALTH DEPARTMENT--CITY OF BALTIMORE D.49213

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 79

CITY OF BALTIMORE (No. 12 Poultney st. ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regina M. Wagner.

(Residence in Baltimore: No. 12 Poultney, St.: 52 yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female.	White.	Widow.

6-DATE OF BIRTH June 9th. 1868, 1 (Month) (Day) (Year)

7-AGE 52 yrs. 6 mos. 14 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany.

PARENTS

10-NAME OF FATHER John Klemann.

11-BIRTHPLACE OF FATHER (State or country) Germany.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or country) Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna Rogers. (daughter)

(Address) 12 Poultney st.

15- DEC 24 1920, 19.. Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH December 22rd. 1920., 191.. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 22nd. 1920, 191.., to, Dec 22rd. 1920, 191.., that I saw h-er alive on Dec 22rd. 1920, 191.., and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Organic Disease of the heart and Kidneys.

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.

Dec 23, 1920 (Address) 1017 N. Charles st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Cedar Hill | DATE OF BURIAL 12/20, 1920

20-UNDERTAKER D. F. McCully | ADDRESS 130 E. Fay

N.B.-Every item of information should be carefully supplied. Exact statement may be properly classified. Exact statement state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 492147 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 492147

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 27 WARD)

2-FULL NAME Edward Jackson

(a) RESIDENCE. No. 136 Patapsco ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 03

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Wallace Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Susan Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant (Address) Hospital Records U. T. H.

15 DEC 24 1920 19 Robert P. Harrison, Burial Permit Clerk. Registrar

CAUSE OF DEATH to be given on back of certificates. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1920, to Dec. 22, 1920, that I last saw him alive on Dec. 22, 1920, and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum

(Signed) L. J. Bogan, M. D.

12-22-20 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Dec 24 1920
20 UNDERTAKER	ADDRESS

Spec.—5-19-13—M. & T.—500 Bks.

D.49215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49215

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 215 Chatham ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME not named Baby Folkes

(Residence in Baltimore: No. — — — — — St.; ....yrs., ...mos. ....ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, December (Month) 23 (Day), 1920 (Year)

7-AGE, 2 hours ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harrison Folkes

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Jennie M Golden

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison Folkes

(Address) 215 Chatham St

15- DEC 24 1920 ....., 191.....

Robert P. Harrison,
Burial Permit Clerk Registrar.

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23, 8 a.m. 1920, to Dec 23, 10 1920, that I saw him alive on Dec 23 at 10 a.m. 1920, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Primary Cause Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) 1020 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Dec 25....., 1920.

20-UNDERTAKER Chas L Bailey

ADDRESS 142 Fulton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.49216 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1284 Riverside Ave ST.; 24 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Joseph E. Lambert

(Residence in Baltimore: No. 1284 Riverside Ave St.; most of life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 21 (Day), 1861 (Year)

7-AGE, 59 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Railroad Exp Director
(b) General nature of industry, business, or establishment in which employed (or employer): 073

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Joseph Lambert

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Margaret Mitchell

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Amelia Lambert

(Address) 1284 Riverside Ave

15-

Filed DEC 24 1920 19.. Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 18 1920, to Dec 22 1920, that I saw h[illegible] alive on Dec 22 1920, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

To my knowledge (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

To my knowledge (Duration) yrs. 6 mos. ds.

(Signed) Frances A. Carpenter M. D.

Dec 23, 1920 (Address) 2101 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	Dec 25, 1920
20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations or technical terms. Consult physician if necessary. Be particular and answer each question fully. Omission to answer questions often causes unnecessary delay. Please write plainly with pen and ink and use figures wherever possible. Do not forget to answer question 18. Use no ditto marks. Instructions carefully followed will avoid return of certificate for correction. Certificate should be completed, signed and returned within 24 hours after death. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49217

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 W. Mosher St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Westenberger

(a) RESIDENCE. No. 1200 W. Mosher St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 5"1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William G. Westenberger

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susannah Hackenheimer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Benjamin James
(Address) 1200 W. Mosher St.

15 Filed DEC 24 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22" 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to Dec. 22, 1920, that I last saw her alive on Dec. 22, 1920, and that death occurred, on the date stated above, at 9-15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chest Expn. advanced symptoms

(Signed) Chas. L. McCandlish, M. D.

19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec 25' 20 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 Baltimore St

CAUSE OF DEATH must be plainly written. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49218 ✓ D.49218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 Union Ave ST., Wilhelm Park 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brigetta A. Bauer

(a) RESIDENCE. NO. 103 Union Ave. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gottlieb Bauer

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm. F. Bauer

(Address) 103 Union Ave

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

DEC 24 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Dec 24, 1920, that I last saw h.. alive on Dec 23, 1920, and that death occurred, on the date stated above, at 4.0 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

19 14 , 1920 Address 2027 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 27, 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 100 3 N. Eutaw Street

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

D.49219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49219

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841½ N. Lombard. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Paul Koch

(Residence in Baltimore: No. 841½ W. Lombard St. St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June 8" (Month) (Day), 1852 (Year)

7-AGE, 68 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Turner and Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country). Prussia, Germany

PARENTS.

10-NAME OF FATHER. Andrew Koch

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma F. Koch

(Address) 841½ W. Lombard St

15-

DEC 24 1920

Robert P. Harrison, M.D.
Registrar.

Burial Permit Clerk.]

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3d 1920, to Dec 22 1920, that I saw h im alive on Dec 22 1920, and that death occurred, on the date stated above, at 11 50 PM

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) 1 yrs. 6 mos. 19 ds.

(Signed) Geo Gillespie M. D.

Dec 23, 1920 (Address) 222 W. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Dec 27", 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49220 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49220

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N Carey ST.; 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hesler

(a) RESIDENCE. NO. 921 Lemmon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2 mo 14		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ferd F. Hesler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie C. Kershner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Ferd F. Hesler

(Address) 921 Lemon St

DEC 24 1920 Filed 19 Robert P. Hartleon Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to Dec 23, 1920, that I last saw h.. alive on Dec 23, 1920, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. Clift, M. D.

12/23, 1920 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Dec 24 1920
20 UNDERTAKER John F. Cowan & Son	ADDRESS 901 Hollins

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.49221 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49221

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3208 Phil. Av ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Benner

(Residence in Baltimore: No. 3208 Phil. Av St.; Life yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. (Month) 20th (Day), 1876 (Year)

7-AGE, 44 yrs. 2 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), B. City

PARENTS.

10-NAME OF FATHER, Henry Benner

11-BIRTHPLACE OF FATHER (State or Country), B. City

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Benner

(Address) 3208 Phila. Ave

15- Filed DEC 24 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

Cause of death must be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Dec 23 1920, that I saw him alive on Dec 22 1920, and that death occurred, on the date stated above, at 5-15 p. m.

The CAUSE OF DEATH* was as follows: Carcinoma of the Stomach

Multiple Thrombosis Mesenteric Veins

Lower Extremities and Left Arm

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs. 3 mos.....ds.

(Signed) Geo. L. McElwee M. D.

Dec 23, 1920. (Address) 6 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Jan. 3rd., 1921.

20-UNDERTAKER Geo. J. Roth. ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49222

CERTIFICATE OF DEATH.

92-120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 W Camden St ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Russell.

(a) RESIDENCE. No. 1411 W Camden St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Russell

6 DATE OF BIRTH (month, day, and year) 2-2-37

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84.	1837	Feb. 10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. H. Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Raborg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) 3314 Wyanoke Ave. Mrs Walden

15 Filed DEC 24 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 20th, 1920, to Dec 24, 1920, that I last saw her alive on Dec 24, 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar.

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. D. Cox M.D.

12/24 1920 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Conn

DATE OF BURIAL Dec 27 1920

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049223 1049223

CERTIFICATE OF DEATH.

+45

1-PLACE OF DEATH Union Memorial Hospital 14 REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin E. Wolff.

(a) RESIDENCE. NO. New York. ST., WARD. Rochester, New York

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or, ~~WIFE of~~) Mrs. Martin E. Wolff.

6 DATE OF BIRTH (month, day, and year) June 28th, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Broker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City.
(State or country)

PARENTS

10 NAME OF FATHER Elias Wolff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Babetta Baer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Simon Stein
(Address) Rochester New York

15 DEC 25 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 24th 1920

17

I HEREBY CERTIFY, That I attended deceased from December 12th, 1920, to December 24th, 1920, that I last saw him alive on December 24th, 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas.

(duration) yrs. 8 (?) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of December 13th, 1920.

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) J. W. Hinman, M. D.

Dec 24th 1920 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rochester New York	Dec 25 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Park Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ld49224 HEALTH DEPARTMENT—CITY OF BALTIMORE Ld49224

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Schaeffer

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood worker

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) France
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

12 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed DEC 25 1920 ROBERT E KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to December 23 1920, that I last saw him alive on December 22, 1920, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis. (No cerebral hemorrhage) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) B Hartman, M. D.

12/23/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Dec 25 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw St.

CAUSE OF DEATH in plain terms, and TION is very important. See instructions on back of

Spec.—5-19-13—M. & T.—500 Bks.

049225

HEALTH DEPARTMENT—CITY OF BALTIMORE

049225

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 - 23 rd ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Maud Leibensperger

(Residence in Baltimore: No. 545 - 23 rd St.; yrs., mos. Life ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ..., 1898
(Month) (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 509

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: C. L. Leibensperger

11-BIRTHPLACE OF FATHER (State or Country): W. Va.

12-MAIDEN NAME OF MOTHER: Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country): Burke Co Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Leibensperger

(Address) 545 C 23rd St

15-

Filed DEC 25 1920 ROBERT B KRAUTER
Burial Permit Clerk.

CAUSE OF DEATH. This line must be filled out. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 / 23 , 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/1 1919, to 12/23 1920, that I saw h er alive on 12/23 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) General Debility

(Duration) 1 yrs. ... mos. ... ds.

(Signed) H. Stanley Gompf M. D.

12/23, 1920 (Address) 1900 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL, 12/25 1920

20-UNDERTAKER: J. F. Lakey & Son — ADDRESS 318 Eight St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049226 HEALTH DEPARTMENT—CITY OF BALTIMORE 049226

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2719 St Calvert ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth S Craig

(a) RESIDENCE. No. 2719 St Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 15 48

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James L. Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eleanor Craig (Address) 2719 St Calvert

Filed DEC 25 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

C. Watkins 2228 St Paul

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 23, 1920, that I last saw h.er alive on Dec 23, 1920, and that death occurred, on the date stated above, at 11-45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage —

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Wm J Walsh, M. D.

(Address) 724 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12/29/20
20 UNDERTAKER	ADDRESS
William Cook	502 E Saratoga

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

L49227 HEALTH DEPARTMENT—CITY OF BALTIMORE L49227

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Webb Carpenter

(a) RESIDENCE. No. 32 Henrietta St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co., Maryland

PARENTS

10 NAME OF FATHER George Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lenora Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital

15 Filed DEC 25 1920 19 ROBERT P. BEAUTER Registrar Burial Permit Otsy

CAUSE OF DEATH in plain terms, so that it may be readily understood. Do not use abbreviations or technical terms. Carefully read the rules on back of certificates. ATTENTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1920. to December 23 1920.

that I last saw him alive on December 23, 1920.

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus.

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Urinary analysis

(Signed) Patterson M. D.

12/24/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 27 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. Madison

Spec. 6-9-19—H. P. Co.—1000 Bks.

D49228 HEALTH DEPARTMENT—CITY OF BALTIMORE D49228

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 533 McMechen ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hiram Conaway

(a) RESIDENCE. No. 533 Mc Mechen ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 11 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Conaway

6 DATE OF BIRTH (month, day, and year) Aug 22. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman & Merchant 066

(b) General nature of industry, business, or establishment in which employed (or employer) Grocers Coal

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel A. Conaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Laura Dixon

(Address) 1406 McCulloh

15 Filed DEC 25 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to Dec 22, 1920, that I last saw him alive on Dec 22, 1920, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis ?

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum Negative Typical

(Signed) Wm H. Wright M. D.

Dec 23 1920 (Address) 120 Prestman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northeastland Co Va Blackwell Cemetery	Dec 29 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS
	1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

049229 HEALTH DEPARTMENT--CITY OF BALTIMORE 049229

1PLACE OF DEATH

CERTIFICATE OF DEATH

120

REGISTERED No. C .....

CITY OF BALTIMORE (No. 408 E. Twenty-fifth St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Evans Curry

(Residence in Baltimore: No. 408 E. Twenty-fifth St.; 75 yrs. 8 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: April (Month) 5 (Day), 1845 (Year)

7-AGE: 75 yrs. 8 mos. 18 ds. If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore, Maryland

PARENTS

10-NAME OF FATHER: Richard Evans

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Rose Gallagher

13-BIRTHPLACE OF MOTHER (State or country): Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. William Curry

(Address) 408 E. Twenty-fifth St.

DEC 25 1920 ROBERT F KRAUTER

Filed ....., 191.... Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 23 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1920, to Dec 23 1920; that I saw h.. alive on Dec 23, 1920, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 10 yrs. ... mos. ... ds

Contributory (SECONDARY) Arteria Sclerosis - Hyp.

(Duration) ... yrs. ... mos. 2 ds.

(Signed) A L McCarty M. D.

Dec 24, 1920 (Address) 311 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 12/27, 1920

20-UNDERTAKER: Henry W. Myers & Son

ADDRESS: 805 N. Calvert St.

N. B.-Every item of information should be carefully supplied. Address must be given in full. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49230 HEALTH DEPARTMENT—CITY OF BALTIMORE D49230

CERTIFICATE OF DEATH. 80

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Eutaw Place, ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie D.Altshul,

(a) RESIDENCE. NO. 1623 Eutaw Place, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? lifetime, yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugo V.Altshul,

6 DATE OF BIRTH (month, day, and year) Feb. 7th. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.Md.

PARENTS

10 NAME OF FATHER Uriah Altshul,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Henrietta Liebman,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant H.V.Altshul,

(Address) 1623 E.PL.

15 Filed DEC 25 1920 ROBERT P KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.24th. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 19th, 1920, to Dec 24, 1920, that I last saw her alive on Dec 24, 1920, and that death occurred, on the date stated above, at 8.10 — m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris - Chronic Nephritis -

(duration) May yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilitation -

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination -

(Signed) Chas Lawrence — M. D.

Dec 25, 1920 (Address) 1327 Park Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai,

DATE OF BURIAL Dec. 26. 1920

20 UNDERTAKER Ward Goodheim

ADDRESS 118 W Lexington St

CAUSE OF DEATH to plain terms, avoiding use of abbreviations or technical terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L 49231 HEALTH DEPARTMENT—CITY OF BALTIMORE L 49231

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 933 N. Calvert ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hetty L. Wells

(a) RESIDENCE. NO. 933 N. Calvert ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Galveston, Texas

PARENTS

10 NAME OF FATHER: William Henry Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER: Frances E. Lamping

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: H. W. Mears & Son's Records
(Address): 805 N. Calvert Street

15 Filed DEC 25 1920 19 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 24th 1920

17 I HEREBY CERTIFY, That I attended deceased from MARCH 26th, 1920, to DEC. 23rd, 1920, that I last saw h.cr alive on DECEMBER 23rd, 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

CARCINOMA of RIGHT BREAST

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) METASTASIS To LIVER SPLEEN.

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Dying to Invest - in Texas

Did an operation precede death? No Date of Inoperable

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Dec 24, 1920 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	12/25 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49232 HEALTH DEPARTMENT—CITY OF BALTIMORE D49232

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3505 Windsor Mill Rd ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary J McCrea

(a) RESIDENCE. NO. 3505 Windsor Mill Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel McCrea

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn, N. Y.

PARENTS

10 NAME OF FATHER --------Brickley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. S. Clautice
(Address) 1411 Mt. Royal Ave.

15 Filed DEC 25 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-23- 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov-14-, 1920, to Dec-23, 1920, that I last saw her alive on Dec. 18—, 1920, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis with Chronic Myocardial degeneration. Acute dilatation.

(duration) ? yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical symps.

(Signed) Harley Cole M. D.

12/24 19 (Address) 202 Bonsay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/27/20 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

049233 HEALTH DEPARTMENT—CITY OF BALTIMORE 049233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; H.P.H.C. East WARD) REGISTERED No. C

2-FULL NAME Lucy M. Camden

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Johns Hopkins Hospital Balt Md St.; ...yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, September (Month) 29 (Day), 1871 (Year)

7-AGE, 49 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Patrick Co. Va

PARENTS.

10-NAME OF FATHER, J. R. Campbell

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER — Arthur

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nealie B. Hohman

(Address) Johns Hopkins Hospital

15- Filed DEC 25 1920 191... ROBERT E [illegible] Registrar.

CAUSE OF DEATH: Particularly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1920, to Dec 24 1920, that I saw h[illegible] alive on Dec 23rd 1920, and that death occurred, on the date stated above, at 8.45 p m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis; myocardial insufficiency

(3)

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(Duration) ...yrs. ...mos. 1/4 ds.

(Signed) Nealie B. Hohman M. D.

..., 191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 2 ds. In the State ...yrs. ...mos. 2 ds.

Where was disease contracted, if not at place of death? Dillwyn Va

Former or usual residence Dillwyn Va

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Dillwyn Va	Dec 27, 191..
20-UNDERTAKER H C Hughes	ADDRESS Dillwyn Va

D49234 HEALTH DEPARTMENT—CITY OF BALTIMORE D49234

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2816 Hudson St ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Jones

(Residence in Baltimore: No. 2816 Hudson St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Morkas

(Address) 2816 Hudson St

15- Filed DEC 25 1920 191..... ROBERT B KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Theus Ryan Jones Cor M. D. (Coroner.)

Dec 25 1920 (Address) 1 Boot & Estate St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Dec 25, 1920

20-UNDERTAKER H E Hughes — ADDRESS 1121 N Broadway

N.B.—Every item of information should be carefully supplied. Each statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1049235 — 1049235

9 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 North Chapel ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda F Zezulinski

(a) RESIDENCE. No. 8 N Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Zezelinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Zudowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Zezulinski (Address) 8 N Chapel

15 DEC 25 1920 ROBERT F KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Dec 24, 1920, that I last saw h.e alive on Dec 24, 1920, and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Antitoxin Injection Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J Wachter, M. D.

, 19 20 (Address) 420 Binney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 25 1920
20 UNDERTAKER	ADDRESS
John R Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49236 HEALTH DEPARTMENT—CITY OF BALTIMORE L49236

CERTIFICATE OF DEATH. Rapling 19-80

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Furby Ave. near Bowleys Lane ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony J. Fortmiller

(a) RESIDENCE. No. Furby Ave. near Bowleys Lane WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Fortmiller

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Diefold

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Joseph Fortmiller
(Address) Rospeburg Md.

15 Filed DEC 25 1920 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/22, 19 20, to 12/23, 19 20, that I last saw him alive on 12/23, 19 ..., and that death occurred, on the date stated above, at 12 05 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy. Mitr.,

CONTRIBUTORY (Secondary) Varicella (duration) ..... yrs. ..... mos. ..... ds.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

12/24, 1920 (Signed) J. J. Rance M. D.
(Address) 2139 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 26 1920
20 UNDERTAKER	ADDRESS
Fred'k Eastman & Sons	Fullerton

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049237

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049237

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 27 WARD)

2-FULL NAME George F. Oyeman

(a) RESIDENCE. No. 11 Montana Ave Raspeburg WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine M. Oyeman

6 DATE OF BIRTH (month, day, and year) Sept 6th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer Wilcox & Riegler Gardenville

9 BIRTHPLACE (city or town) (State or country) Gardenville Md.

PARENTS

10 NAME OF FATHER Robt. F. Oyeman

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie M. Gantrum

13 BIRTHPLACE OF MOTHER (city or town) Gardenville (State or country) Md

14 Informant Robt. F. Oyeman (Address) Raspeburg Md.

15 Filed DEC 25 1920 19 ROBERT J. KRAUTER Registrar

Burial Permit Oleas

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 1920, to Dec. 24, 1920, that I last saw h.. alive on Dec 24, 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
General Peritonitis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? Yes Date of Nov 23 20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. F. Thompson, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 27 1920
20 UNDERTAKER Frank Lasahn & Sons	ADDRESS Fullerton

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. See instructions on back of certificates. TION is very important.

D 49238 HEALTH DEPARTMENT—CITY OF BALTIMORE 49238

CERTIFICATE OF DEATH. 172

1-PLACE OF DEATH REGISTERED No. C

CITY OF BALTIMORE (No. Lorraine Head at Mercy St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Freund

(Residence in Baltimore: No. 916 N. Carlton St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Man	W.	S

6-DATE OF BIRTH, April (Month) 23 (Day), 1897 (Year)

7-AGE, 23 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stud Serv
(b) General nature of industry, business, or establishment in which employed (or employer): Univ

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, L. Freund

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Reg. Landgraff

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos J Buchanan

(Address) 2396 Valentine Av.

15- Filed DEC 26 1920, 191 ROBERT E REGISTER Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1919 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull - and internal injuries Caused by fall at Home Entrance the Same (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

Dec 25, 1919 (Address) 1629 Bus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New York City	Dec 27, 1919
20-UNDERTAKER George J Smith	ADDRESS 1300 N Eutaw St.

N. B.—Every item of information must be given as accurately as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L049239 HEALTH DEPARTMENT—CITY OF BALTIMORE L049239

CERTIFICATE OF DEATH. 5 40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Hatten

(a) RESIDENCE. No. 336 Forest St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Denis Hatten

11 BIRTHPLACE OF FATHER (city or town) Harford Co., (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed DEC 26 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 15, 1920, to December 23, 1920, that I last saw him alive on December 23, 1920, and that death occurred, on the date stated above, at 11 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pyloric obstruction

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Gastric analysis

(Signed) J. B. Herman, M. D.

12/24/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cemetery	Dec. 26 1920
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	426 N. Carrollton

CAUSE OF DEATH in plain terms, so that it can be understood by any physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49240

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. St James apt St. 11 WARD) T. M.

2-FULL NAME George Gibson

(a) RESIDENCE. No. St James apts ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenia Margie Gibson

6 DATE OF BIRTH (month, day, and year) Dec 19 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Geo S. Gibson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Beasley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant J Shaw Margie
(Address) Catonsville Md.

15 Filed DEC 26 1920 ROBERT F. LEADER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Dec 24, 1920, that I last saw h-im alive on Dec 24, 1920, and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Uremia

over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute parenchymatous nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urine analysis and

(Signed) W O Ridgely, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old St Paul Cemetery	Dec 27 1920
20 UNDERTAKER	**ADDRESS**
Henry Jenkins Sons Co	Richard & Fairfield

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

W49241

HEALTH DEPARTMENT—CITY OF BALTIMORE

W49241

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Latrobe St. ST.; 12 151 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Quenton Robinson

(a) RESIDENCE. No. 1605 Latrobe St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

15 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1920

7 AGE — Years — Months — Days: 5 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Gertrude Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Samuel Robinson (Address) 1605 Latrobe St

15 Filed DEC 26 1920

16 ROBERT B. BRAUTIGAM Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920, to Dec 22, 1920, that I last saw him alive on Dec 22nd, 1920, and that death occurred, on the date stated above, at 10 45 p.m.

The CAUSE OF DEATH* was as follows:

Marasmus Rickets and premature Birth

(duration) x yrs. x mos. 8 ds.

CONTRIBUTORY (Secondary) Physical condition of the mother (duration) x yrs. 9 mos. x ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Geo. L. Kuhl, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: Dec 26 1920

20 UNDERTAKER: Wm. L. Kemsley — ADDRESS: Biddle

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See instructions on back of certificates. TION is very important.

10 30

Spec.—6-9-19—H. P. Co.—1000 Bks.

049242

HEALTH DEPARTMENT—CITY OF BALTIMORE

049242

CERTIFICATE OF DEATH.

92-010

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 502 Moore ST. 17 WARD)

2-FULL NAME Stephen Goodwater

(a) RESIDENCE. NO. 735 Little George ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife Unknown.

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jas. M. Seward

(Address) 1005 Druid Hill Ave

15 Filed DEC 26 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Dec 24, 1920, that I last saw him alive on Dec 24, 1920, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 735 Little George St

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis? none

(Signed) J. R. Coggsey, M. D.

, 19 (Address) 733 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn, Cem. DATE OF BURIAL: Dec 26 1920

20 UNDERTAKER: Samuel Kinsley ADDRESS 578 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

D49243 HEALTH DEPARTMENT—CITY OF BALTIMORE D49243

CERTIFICATE OF DEATH.

167

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Mackey

(Residence in Baltimore: No. 1307 N Calhoun St.; (yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH. Dec 1, 1863 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
57 yrs. mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER. Wm Newman

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Margaret Askins

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence E Mackey

(Address) 524 Mission St.

15- DEC 26 1920 ROBERT F LITTLE

Filed....., 191. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3d Degree burns over Greater part of body accident while Ironing fire dress caught

(Duration) ..... yrs. 1½ ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. mos. 1 ds.

(Signed) James M Pentz M. D. (Coroner.)

Dec 23, 1920 (Address) 702 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ..... yrs. ..... mos. ½ ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1307 N Calhoun St

Former or usual residence 1307 N Calhoun St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt E. Cemetery	Dec 26 1920.

20-UNDERTAKER Samuel Hendy ADDRESS 1709 Bridge St

N. B.—Every item of information called for should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49244 HEALTH DEPARTMENT—CITY OF BALTIMORE D49244

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 S. Stricker ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ford

(a) RESIDENCE. No. 807 S. Stricker ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse shoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John C. Ford

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann Bauer.

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant John C. Ford
(Address) 807 S. Stricker St.

15 DEC 26 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1920, to Dec 24, 1920, that I last saw him alive on Dec 22, 1920, and that death occurred, on the date stated above, at 12.35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. McAvoy, M. D.

12/25 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Dec. 27 1920
20 UNDERTAKER Lilly and Zirkin	ADDRESS 403 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

049245 HEALTH DEPARTMENT—CITY OF BALTIMORE 049245

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH 1115 Brentwood Ave

CITY OF BALTIMORE: (No.) 1115 Brentwood Ave (St.) 10 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Virgil Mitchell

(a) RESIDENCE. NO. 1115 Brentwood ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married, Widowed, or Divorced~~ (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Thos. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Harriett Litsinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs. L. L. Gross

(Address) 1115 Brentwood Ave

15 Filed DEC 26 1920 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1920.

17

I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1920, to Dec 25, 1920, that I last saw h~~e~~ alive on Dec 25, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema - Valvular disease of heart

followed by

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Gangrene of left lower extremity

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 23/20

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs and autopsy findings

(Signed) J. C. B. Normal, M. D.

, 19 (Address) 3347 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet M.E. - Balto Co.	Dec 27th 1920
20 UNDERTAKER Bertram & Fox	ADDRESS 1723 N. Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the people. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49246

43

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Harford Road ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Em. Korb.

(a) RESIDENCE. NO. 204 Harford Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred? life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married~~, Widowed or Divorced (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew V. Lott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa M Hoen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) E. W. Giles 1522 W. Pratt St

15 Filed DEC 26 1920 19 [illegible] Burial Permit [illegible] Registrar

CAUSE OF DEATH in plain terms, so that it may be correctly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24 Dec. 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1920, to Dec 24, 1920, that I last saw h.e alive on Dec 24, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmond flexure of colon (Secondary)

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 1918

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J Thomas Nelson, M. D.

, 19 (Address) 1001 2 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 28 19 20
20 UNDERTAKER	ADDRESS
P. Lott	1237 Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49247 HEALTH DEPARTMENT—CITY OF BALTIMORE L49247

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hosp. REGISTERED NO. 64

CITY OF BALTIMORE: (No. 418 W. Lexington St. St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Julia Edna Parks

(a) RESIDENCE. No. ~~Volunteers of America Hosp.~~ ~~418 W. Lexington St.~~ 113 W. Saratoga St. St. ~~Hosp.~~ Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Divorced

5a If ~~married, widowed, or~~ divorced ~~HUSBAND of~~ (or) WIFE of: John E. Parks

6 DATE OF BIRTH (month, day, and year): October 5 1888

7 AGE: Years 32 Months 2 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Charge of Dept

(b) General nature of industry, business, or establishment in which employed (or employer): Lunch Counter

(c) Name of employer: Admiral Hotel

9 BIRTHPLACE (city or town) (State or country): Glyndon Baltimore Co Md

PARENTS

10 NAME OF FATHER: Joseph Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co. Md

12 MAIDEN NAME OF MOTHER: Florence E. Hutchins

13 BIRTHPLACE OF MOTHER (city or ~~town~~) (State or country): Ellicott Howard Co Md

14 Informant: Mrs J.B. Shroyer (Address) Reisterstown, Md

15 Filed DEC 26 1920 ROBERT F. HEASTE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 26 — 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1920, to Dec. 25, 1920, that I last saw her alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, due, probably, to Cerebral-Haemorrhage.

OTW

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Parenchymatous nephritis (?) (duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) J. L. Rayewall, M. D.

12/26, 1920 (Address) 418 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Loudon Park — DATE OF BURIAL: Dec 27 1920

20 UNDERTAKER: Geo W Little — ADDRESS: 531 N. Fremont Av

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Omit abbreviations and technical terms. Do not use the words "Disease," "Cancer," "Tumor," "Abscess," "Paralysis," "Dropsy," "Fever," "Heart Trouble," "Kidney Trouble," "Blood Poisoning," "Convulsions," "Old Age," "Infantile Debility," "Premature Birth," "Childbirth," "Accident," "Suicide," "Homicide," or "Sudden Death," without stating the cause on which they depend. If from violence, state the means and nature of injury. Write plainly in ink. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049248 HEALTH DEPARTMENT—CITY OF BALTIMORE 049248

CERTIFICATE OF DEATH. 28

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Naco

(a) RESIDENCE. NO. 2115 Oak St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Naco

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bevenns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Wilsie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. T. H.

Filed DEC 26 1920 BURNEY B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Dec. 24, 1920, that I last saw her alive on Dec. 24, 1920, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

3 mos. ds.

(duration) yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Lo. S. Fahndrich, M. D.

12--20. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Cem. Hampden.

DATE OF BURIAL 12/27 1920

20 UNDERTAKER Walter Davis

ADDRESS 3307 Paine St.

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49249 — 91-084 — D49249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1404 E. Madison ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice Veney

(a) RESIDENCE. NO. 1404 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) July 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None a child

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mathus Venney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eunice Penny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant by Foster Mathus Veney (Address) 1404 E Madison St

15 Filed DEC 26 1920 ROBERT A. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Dec. 23, 1920, that I last saw h[illegible] alive on Dec. 23, 1920, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Subacute bronchitis (duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. B. Robinson M. D.

(Address) 1535 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery DATE OF BURIAL Dec 28 1920

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be understood by a stranger. Name of disease alone is not sufficient. Omission to state the cause of death in proper terms, or the use of indefinite terms, such as "fever," "debility," "old age," "dropsy," "convulsions," "paralysis," "cancer," "consumption," "tumor," "abscess," "inflammation," "hemorrhage," "accident," "suddenly," "found dead," "natural causes," "unknown," "not known," "not stated," "not given," "not ascertained," "not certified," "not known to informant," "not known to deponent," "not known to me," "not known to the undersigned," "not known to the coroner," "not known to the physician," "not known to the undertaker," "not known to the sexton," "not known to the gravedigger," "not known to the grave-digger," "not known to the grave digger," "not known to the grave-digger," "not known to the grave digger," "not known to the grave-digger," "not known to the grave dig

1049250 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049250

CERTIFICATE OF DEATH.

REGISTERED No. C 1379

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Grace Church Nicholson St. 1463 WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca E. Bosley

(Residence in Baltimore: No. 830 W. 37 St.; St.: (yrs. 14 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: May (Month) 5 (Day), 1850 (Year)

7-AGE: 70 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Carroll Co Md

PARENTS.

10-NAME OF FATHER: Jacob Reagle

11-BIRTHPLACE OF FATHER (State or Country): Carroll Co Md

12-MAIDEN NAME OF MOTHER: Cecila Neumaker

13-BIRTHPLACE OF MOTHER (State or Country): Carroll Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Cecilia Bosley
(Address): 1830 W 37 St

15- DEC 26 1920 Filed....., 191.... ROBERT P. LEA[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

Dec 28, 1920 (Address) 3732 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Dolan Church Bethesda (DATE OF BURIAL, Dec 28, 1920)

20-UNDERTAKER: J S Mac[illegible] ADDRESS: 2509 Fall[illegible]

N. B.—Every item of information should be carefully given, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049251 HEALTH DEPARTMENT—CITY OF BALTIMORE 049251

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3403 Morris Av. ST.: 15 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. William Henry Dunbar DD (Resident)

(a) RESIDENCE. No. 3403 Morris ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 68 yrs. 10 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Dunbar

6 DATE OF BIRTH (month, day, and year) Jany 25-1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) Pastor Emeritus

(c) Name of employer St Mark's Lutheran Church

9 BIRTHPLACE (city or town) (State or country) Stone Church North Hampton Co. Penna.

PARENTS

10 NAME OF FATHER Robert Dunbar

11 BIRTHPLACE OF FATHER (city or town) Stone Church (State or country) Penna

12 MAIDEN NAME OF MOTHER Susan Correll

13 BIRTHPLACE OF MOTHER (city or town) Stone Church (State or country) Penna.

14 Informant Mr. P. B. Dunbar (son) (Address) Washington D.C.

Filed DEC 26 1920 ROBERT F. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Dec 24, 1920, that I last saw h.. alive on Dec 23, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis-

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs and Laboratory findings

(Signed) Wm J. Watson, M. D.

Dec 24 1920 (Address) 1128 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton - Penna	Dec 27 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49252 HEALTH DEPARTMENT—CITY OF BALTIMORE D49252

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 E. Biddle ST.: 10 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Ireland

(a) RESIDENCE. NO. 1425 E. Biddle ST., WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? 79 yrs 9 mos. 23 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) March-2-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Ireland

11 BIRTHPLACE OF FATHER (city or town) ?? (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Cummings

13 BIRTHPLACE OF MOTHER (city or town) ?? (State or country) Ireland

14 Informant Mr. A. L. Jackson (Address) Md. Cas. Tower Bldg.

15 Filed DEC 26 1920 ROBERT F. FOERSTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Dec 25, 1920, that I last saw h alive on Dec 25, 1920, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. Offerman Bruce, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Dec 27/ 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49253 HEALTH DEPARTMENT—CITY OF BALTIMORE D49253

CERTIFICATE OF DEATH. 45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland General Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry La Porte

(a) RESIDENCE. NO. 2317 Arunah Ave ST., 16 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? 78 yrs. 7 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia M. LaPorte

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Frocks

(b) General nature of industry, business, or establishment in which employed (or employer) Florence MacCarthy

(c) Name of employer Company. Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry La Porte

11 BIRTHPLACE OF FATHER (city or town) ?? (State or country) Prussia

12 MAIDEN NAME OF MOTHER Eliz. Stalfort

13 BIRTHPLACE OF MOTHER (city or town) ?? (State or country) Prussia

14 Informant Robt. H. La Porte (Son) (Address) 2317 Baltimore Ave City

15 Filed DEC 30 1920, 19 ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1920, to Dec. 25, 1920, that I last saw h im alive on Dec. 24, 1920, and that death occurred, on the date stated above, at 1.45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-21-20

Was there an autopsy? yes

What test confirmed diagnosis? microscopic

(Signed) Howard Mathieson Buhrer M. D.

19 (Address) M G H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 27 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

mation should be carefully written in ink, and in plain terms, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

D49254 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D49254

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 104 25

CITY OF BALTIMORE (No. Herkemier ST.: (WARD)

2 FULL NAME Roland Goodrich Schanken

(Residence in Baltimore: No. 1 Herkemier Morrell Park St.: yrs. 6 mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 14 (Day), 1920 (Year)

7 AGE: — yrs. 6 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 200

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Emil Schanken

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ada M. Goodrich

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emil Schanken

(Address) Herkemier st

15. DEC 26 1920 (Filed) 191 ROBERT B KRAUTER Registrar

Burial Permit 01872

N. B.—Every item of information should be carefully supplied. AGE should be stated so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 24 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 24 1920

that I saw him alive on Dec 23, 1920

and that death occurred, on the date stated above, at 12-45 PM

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY): Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) Geo Fm Kieffer M. D.

Dec 25, 1920 (Address) Morrell Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 27, 1920

20 UNDERTAKER: Hesse Funeral — ADDRESS: 5th Edmondson

D49255 HEALTH DEPARTMENT—CITY OF BALTIMORE D49255

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Hollins ST.: 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah F Langford

(Residence in Baltimore: No. 1118 Hollins St.; (yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH. June 14, 1852
(Month) (Day) (Year)

7-AGE. 68 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE. (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Wm Barbett

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Frances Bennett

13-BIRTHPLACE OF MOTHER (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin L Hax

(Address) 111 S Hollins

15- DEC 26 1920 ROBERT P KRAUTER
Filed....., 191.....
Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ....yrs.....mos.....ds.

(Signed) James M Penton M. D.
(Coroner.)

Dec 26, 1920 (Address) 700 Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Dec 28, 1920
20-UNDERTAKER	ADDRESS
George J Smith	1008 N Gay

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is especially important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49256 HEALTH DEPARTMENT—CITY OF BALTIMORE D49256

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Mercy Hosp. ST. 14 WARD)

2-FULL NAME Miss Frances C Donnell

(a) RESIDENCE. NO. 1516 Eutaw Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 12 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Matthew O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bedelia McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss C. Donnell. (Address) 1516 Eutaw Place

15 Filed DEC 26 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/13 1920 to 12/24 1920, that I last saw h— alive on 12/21 1920, and that death occurred, on the date stated above, at 12.10 m.

The CAUSE OF DEATH* was as follows:

Prolapse of Uterus - Chronic Adhesive Inflammation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 40 min.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/17/20

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Simon E. Robey M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Dec. 27 1920
20 UNDERTAKER	ADDRESS
Martin Fakey & Son	1827 N North

mation should be given in plain terms, so that it may be properly ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... k of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049257

HEALTH DEPARTMENT—CITY OF BALTIMORE

049257

151

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hagaman

(a) RESIDENCE. No. 223 E Biddle St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Sing.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) not any

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leon C. Hagaman

11 BIRTHPLACE OF FATHER (city or town) Hagerstown (State or country) Md. do not know

12 MAIDEN NAME OF MOTHER Florence G. Anderson

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Leon C Hagaman (Address)

15 Filed Dec 25 1920 ROBERT I. KLAUTER Registrar

DEC 26 1920 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-25- 1920, to 12-25- 1920, that I last saw h[illegible] alive on 12-25- 1920 and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Immaturity OVER

(Foetus 6 mo. old)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Atelectasis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical exam.

(Signed) Paul E. Brown, M. D.

12-24 1920 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Dec 27 1920
20 UNDERTAKER	ADDRESS
Henry W Myers & Son	806 N Calvert

mation should be entered in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Child only 1 hr. old.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049258

HEALTH DEPARTMENT—CITY OF BALTIMORE

049258

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Guilford Avenue St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel W. Taulman

(a) RESIDENCE. No. 2412 Guilford Avenue St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Sullivan

6 DATE OF BIRTH (month, day, and year) June 16, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) Do not know
(State or country)

12 MAIDEN NAME OF MOTHER Salome Lake

13 BIRTHPLACE OF MOTHER (city or town) Do not know
(State or country)

14 Informant Mrs. Blanche B. Bender
(Address) 2412 Guilford Avenue

15 DEC 26 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1920, to Dec 23, 1920, that I last saw h[illegible] alive on Dec 23, 1920, and that death occurred, on the date stated above, at 9.45A.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis — 6 yrs ?
Senile Dementia 4 wks
Chronic Nephritis 1 yr.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? "Clinical"

(Signed) E Hilles Fleming, M. D.

12/26, 1920 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Yonkers St. Mary's Cemetery, N. Y.	12/29 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49259 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D49259

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No 1330 Sargeant ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard Morhiser

(a) RESIDENCE. No 1330 Sargeant ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 30 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways +

(c) Name of employer Electric Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John S Morhiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ellen N Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ellen N Morhiser

(Address) 1330 Sargeant St

15 Filed DEC 26 1920 ROBERT E KRAUTER Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Dec 24, 1920, that I last saw him alive on Dec 24, 1920, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G D Buxton, M. D.

12/26 1920 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 28 1920
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 Walbert St

IMPORTANT: Write plainly with ink. Make no abbreviations. Do not use ditto marks. Be sure to answer every question. If none, write none. If unknown, say unknown. Do not omit any information which you may possess. Make a separate certificate for each death. Do not confuse CAUSE OF DEATH in plain terms, so that it may be understood by a person not a physician. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49260 HEALTH DEPARTMENT—CITY OF BALTIMORE D49260

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1152 West Hamburg St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Shriver

(a) RESIDENCE. No. 1152 West Hamburg ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Shriver

6 DATE OF BIRTH (month, day, and year) Dec. 22nd 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Shriver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Sarah E. Shriver

(Address) 1152 West Hamburg St.

15 Filed DEC 26 1920 SOLLY I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1920, to Dec 24, 1920, that I last saw h~ alive on Dec 24, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ~ yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of ~

Was there an autopsy? ~

What test confirmed diagnosis?

(Signed) Edw Guenther, M. D.

12/26 19 (Address) 517 Reed St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 28 1920
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Bond St

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D49261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49261

CERTIFICATE OF DEATH

Hamilton 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Magnolia ave ST.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E - Curran

(Residence in Baltimore: No. 2 Magnolia ave St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, Dec 1st, 1863
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
57 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas Coughlin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Lynch

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Curran

(Address) 2 Magnolia Ave

15-

Filed DEC 26 1920 191.... ROBERT E KRAUTER Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 24 1920, that I saw h.. alive on Dec 24 1920, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Clare Summers M. D.

Dec 24, 1920 (Address) 47 S Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Dec 27 1920
20-UNDERTAKER	ADDRESS
Margaret E Flynn	1427 Eutaw St.

N.B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049262 HEALTH DEPARTMENT—CITY OF BALTIMORE 049262

CERTIFICATE OF DEATH. 1120-091

1-PLACE OF DEATH South Baltimore Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Reinhardt

(a) RESIDENCE. No. 1320 Andre St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Married

3a If married, ~~widowed, or divorced~~
~~HUSBAND of~~
(or) WIFE of Gustaf Reinhardt

6 DATE OF BIRTH (month, day, and year) 12/24/1863

7 AGE: Years 56; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Betcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Luba

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Gustav Reinhardt
(Address) 1320 Andre St.

15 Filed DEC 26 1920 . 19 ... FOREST B. ELANTER Registrar Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 . 1920 . to Dec 24 . 1920 . that I last saw her alive on Dec 24 . 1920 . and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Howard L. Tolson M. D.

. 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Dec 27 1920

20 UNDERTAKER: Margaret G. Flynn ADDRESS: 1422 Light St

mation should be carefully supplied. Exact statement of OCCUPA
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D. 49263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49263

CERTIFICATE OF DEATH.

104

REGISTERED NO. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 718 Singer Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles LeRoy Norman.

(Residence in Baltimore: No. 718 Singer Ave.

St.; yrs., + mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Infant

6-DATE OF BIRTH, Nov. (Month) 26 (Day), 1920 (Year)

7-AGE, 0 yrs. 0 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto city md.

PARENTS.

10-NAME OF FATHER Charles O Norman

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Virginia Goodrich

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas O. Norman

(Address) 508 Taylor St.

15- DEC 27 1920 Filed ....., 191.... Wilmington Del. ROBERT F KRAUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the date stated above.

The CAUSE OF DEATH* was as follows: over

Marasmus.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) Chas O Norman M. D. (Coroner.)

Dec 26 1920 (Address) 3623 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Marys Cem Hampden — DATE OF BURIAL, 12/27, 1920

20-UNDERTAKER J Walter Davis — ADDRESS 3307 Paine St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Gastro Intestinal Disturbance.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

0049264

HEALTH DEPARTMENT—CITY OF BALTIMORE

0049264

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1000 E. Charles St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Steindler.

(Residence in Baltimore: No. 1021 E. Short St. St.; yrs. 78 mos. 0 ds. 10)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, December 14th. 1842, 1 (Month) (Day) (Year)

7-AGE, 78 yrs. 0 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Lillian Lindus.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Sophia Beer.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia K. Rose. (daughter)

(Address) 1021 E. Short St.

15 Filed DEC 27 1929, 191.... ROBERT J. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24th. 1929. (Month) (Day) 1929 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Mo. M. Emanuel M. D. (Coroner.)

Dec. 25th, 29, 191... (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	Dec. 27th, 1929

20-UNDERTAKER Mrs. Mrs. John W. Teufel ADDRESS 811 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D49265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49265

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Hanford Ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Kunnecke

(Residence in Baltimore: No. 3210 Hanford Ave St.; 40 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 1st (Day), 1853 (Year)

7-AGE, 67 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... own

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Moroo

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. L. Kunnecke

(Address) 3210 Hanford Ave

15- Filed DEC 27 1920, 191.... ROBERT F KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 24th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1920, to Dec 24 1920, that I saw her alive on Dec 24th 1920, and that death occurred on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. ... mos. 1 ds.

(Signed) Robert S. Kirk M. D.

Dec 27 1920 (Address) 3136 Hanford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem — DATE OF BURIAL, 12/27/20, 191...

20-UNDERTAKER Geo. J. Roth — ADDRESS 1135 Hanford Ave

N.B.—Every item must be properly answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049266 HEALTH DEPARTMENT—CITY OF BALTIMORE 049266

CERTIFICATE OF DEATH.

28 REGISTERED NO. C .....

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 1312 Sargent ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Day

(Residence in Baltimore: No. 1312 Sargent St.; 43 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Nov 13, 1863 (Month) (Day) (Year)

7-AGE. 57 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Home 800

9-BIRTHPLACE, (State or Country). Elkridge Md

PARENTS.

10-NAME OF FATHER. Evan Buckingham

11-BIRTHPLACE OF FATHER (State or Country). Elkridge Md

12-MAIDEN NAME OF MOTHER Lee Keahler

13-BIRTHPLACE OF MOTHER (State or Country). Elkridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee Keahler

(Address) Elkridge Md

15- ROBERT J KRAUTER

Filed DEC 27 1920 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 24 1920 that I saw h— alive on Dec 24 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) ....yrs. ....mos. 10 ds.

(Signed) Thos. Leas. D. Baker M. D.

Dec 24 1920 (Address) 227 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. — mos. — ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Elkridge M. E. Cem

DATE OF BURIAL, 12-27-1920

20-UNDERTAKER Robert Brooke & Son

ADDRESS 17 S Calhoun St

N. B.—Every item of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Monthly

049267 HEALTH DEPARTMENT—CITY OF BALTIMORE 049267

CERTIFICATE OF DEATH. 165

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Moriarty

(Residence in Baltimore: No. 912 Ryan St

St.(yrs., 48 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Don't Know ....., 1872
(Month) (Day) (Year)

7-AGE, 48 yrs. 0 mos. 0 ds.

If LESS than 1 day, 0 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Hanson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Ann Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Moriarty

(Address) 912 Ryan St

15-

Filed DEC 27 1920 191.... ROBERT J. CRAUER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, ~~autopsy on~~, inquiry.) thereon and from the evidence obtained by said..... ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to.. Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Carbolic Acid Poisoning .....

..... (Duration) ..... yrs. ..... mos. a few hours ds.

CONTRIBUTORY (Secondary) Accidental

..... (Duration) ..... yrs. ..... mos. a few hrs ds.

(Signed) ..... M. D.
(Coroner.)

12-25, 1920 (Address) 117 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, DEC. 28., 1920

20-UNDERTAKER Robert Brokerson

ADDRESS CALHOUN HOLLINS ST

N. B.—Every item of information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049268 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049268

CERTIFICATE OF DEATH. 138

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel R. Stevens

(a) RESIDENCE. NO. 1615 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lester E. Stevens

6 DATE OF BIRTH (month, day, and year) 1891 July 12

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
29		5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER L. D. Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Lottie Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Lester E. Stevens

(Address) 1615 Chapel St

15 Filed DEC 27 1920 ROBERT F. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1920, to Dec. 26, 1920, that I last saw her alive on Dec. 26, 1920, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-26-20

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) T. B. Bromwell, M. D.

12-26 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Frederick Md

DATE OF BURIAL Dec 30 1920

20 UNDERTAKER Robert Brookeson

ADDRESS CALHOUN HOLLINS

N. B.—Blanks should be carefully supplied. Any information should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood, is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Puerperal.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049269

HEALTH DEPARTMENT—CITY OF BALTIMORE

049269

CERTIFICATE OF DEATH.

X120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M. 9 H. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Lauder

(a) RESIDENCE. NO. Leiderstown Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Hukle

6 DATE OF BIRTH (month, day, and year) July 26, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexia (State or country) Maryland

PARENTS

10 NAME OF FATHER John Landers

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Faire

13 BIRTHPLACE OF MOTHER (city or town) Alexia (State or country) Maryland

14 Informant Charles L. Landers

(Address) 1619 N. Payson St. City

15 Filed DEC 27 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1920, to Dec. 26, 1920.

that I last saw h im alive on Dec 26, 1920

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Matheson Bubert M. D.

, 19 (Address) Md Hall.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemt	Dec 29 1920
20 UNDERTAKER Richard Cole	ADDRESS 1723 W Lex

mation should be carefully supplied, that it may be properly classified. Date of death, CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of death, TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49270

CERTIFICATE OF DEATH.

103 D 49270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Creek alley St.; 23 WARD)

2-FULL NAME Mary Lewellyn

(a) RESIDENCE. No. 1008 Creek alley St., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Lewellyn

6 DATE OF BIRTH (month, day, and year) Nov. 16 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Lewellyn 1008 creek alley

15 Filed DEC 27 1920 ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/24/ 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/9/ 1920, to 12/24/ 1920, that I last saw her alive on 12/23/ 1920, and that death occurred, on the date stated above, at 3.30a m.

The CAUSE OF DEATH* was as follows:

Portal Stasis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Engerley, M. D.

12/27/ 1920 (Address) 907 S Chapel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 27 1920
20 UNDERTAKER John H Toadvine	ADDRESS 142 Ostend St

mation should be carefully supplied. Each question should be properly classified. Exact statements are required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are required. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. had been attending some time for chronic gastritis. Portal stasis due to gastritis. Not tubercular. Not cancerous. no further history.

Spec.--8-24-14—M. & T.—2000 Bks.

49271

HEALTH DEPARTMENT—CITY OF BALTIMORE

1202 D 49271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Mount St ST.; 19 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Leonard

(Residence in Baltimore: No. 416 N. Mount St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1861
(Month) (Day) (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

9-BIRTHPLACE, (State or Country), N-C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), N-C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), N-C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Leonard

(Address) 416 N. Mount St.

15-

Filed ....., 191.... ROBERT F KRAUTER Registrar.

DEC 27 1920 Burial Permit Clerk

N. B.—Every item of information should be given in this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct-1 1920, to Dec-24 1920,
that I saw h[illegible] alive on Dec-24 1920,
and that death occurred, on the date stated above, at 11:20 P.M.
The CAUSE OF DEATH* was as follows: R.M.

Acute Valvular Heart Disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) W. T. Coleman M. D.

Dec 24, 1920 (Address) 2338 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Dec 27, 1920
20-UNDERTAKER John H. Toadvine	ADDRESS 143 Ostend St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49272

D49272

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal T.B. Hosp ST.; 4 WARD)

2-FULL NAME William H. Walker.

(a) RESIDENCE. NO. 722 Redwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Mazie Walker.

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Isaiah Walker.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Records. M. J. H.
(Address) Baptism

15 Filed DEC 27 1920 ROBERT J. KLAUTER Registrar
Vital Events Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1920, to Dec 25, 1920, that I last saw him alive on Dec 25, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Positive sputum.

(Signed) Lo. D. Fahndrich, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 28 1920
20 UNDERTAKER John H. Bradburn	ADDRESS 142 Monroe St

Information should be plainly written in ink, and may be typewritten, so that it may be properly classified and indexed. Fill out all items in plain terms, so that it may be readily understood by the Registrar and by the Bureau of Vital Statistics, Washington, D. C., to which a duplicate copy of certificates. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Thomas Thomas

D 49273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49273

CERTIFICATE OF DEATH.

5 65

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 211 Calvin ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Thomas

(a) RESIDENCE. No. 258 Calvin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of Unknown (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Unknown

14 Informant John Watkins (Address) 258 Calvin St.

15 DEC 27 1920 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Dec 23, 1920, that I last saw him alive on Dec. 23, 1920, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas J Green M. D

12-26, 1920 (Address) 1201/2 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind - Auburn Cemetery	Dec 27 1920
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

mation should be carefully supplied. Avoid abbreviations. Write plainly with ink. Do not use lead pencil. Be sure that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to Alcoholism

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49274

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M.G.H. ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Staub

(a) RESIDENCE. NO. M.G.H. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 48hrs How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 21 hrs. or 30 min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Staub

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie May Meyers

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Sadie May Meyers
(Address) 926 Harlem Ave

15 DEC 27 1920 ROBERT F. LEADER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Dec 25, 1920, that I last saw h[illegible] alive on Dec 25, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Kelly Baker, M. D.

, 19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	27 1920
20 UNDERTAKER H. C. Cummings Son	ADDRESS 617 N. Schroeder

mation should be carefully supplied. Any illegible or incomplete answer may be properly classified. Exact statements are required. Read carefully the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are required. Read carefully the instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49276 D49275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 S. Milton ave. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Planner

(a) RESIDENCE. No. 718 S. Milton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Joseph O Planner
(Address): 718 S. Milton ave

15 Filed DEC 27 1920 ROBT. J. BRADLEY Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb —, 1920, to Dec 24, 1920, that I last saw h[illegible] alive on Dec 24, 1920, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) ... yrs. unknown mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Jamesgrath, M. D.

, 19 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cem	Dec. 26 1920

20 UNDERTAKER: Jos. J. Kerr — ADDRESS: 156 N. Luzerne ave

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Larsen

D49276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49276

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 N. Linwood Ave ST.: 6 WARD)

2-FULL NAME John Larsen

(a) RESIDENCE. NO. 2 N Linwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emilie Larsen

6 DATE OF BIRTH (month, day, and year) Aug-12-1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. Herman Larsen

(Address) 2 N Linwood Ave

Filed DEC 27 1920 ROBERT P. KRAJIEL Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Dec 25, 1920, that I last saw him alive on Dec 24, 1920, and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward J. Lovett M. D.

12/25, 1920 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Dec 28 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1310 Fleet Ave

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.

Powell

D49277 HEALTH DEPARTMENT—CITY OF BALTIMORE D49277

79

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (CITY OF BALTIMORE (No. 1111 E. Fremont St.) 3 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James O Powell

(Residence in Baltimore: No. 615½ E Pratt St St. (yrs., 2 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) 1 (Day) ..... (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE. (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, James Powell

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Kat Fraim

13-BIRTHPLACE OF MOTHER (State or Country), Kat Fraim

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H Lander Son

(Address) 1710 Eutaw St

15- Filed DEC 27 1920 191.... ROBERT B KRAUTH Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

Signed) H Lander Son M. D.
(Coroner.)
12/26, 1920 (Address) 1710 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Dec 27, 1920
20-UNDERTAKER	**ADDRESS**
H Lander Son	1710 Eutaw St

N.B.—Every item of information should be carefully supplied. AGE should be stated correctly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

649278

HEALTH DEPARTMENT—CITY OF BALTIMORE

649278

CERTIFICATE OF DEATH

37

1-PLACE OF DEATH Bay View Hospital (If not in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, MD. ST.: V WARD) REGISTERED NO.

2-FULL NAME Philip Rosenberg.

(a) RESIDENCE. NO. 1737 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Fannie Rosenberg

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital
(Address) Balto Md.

15 DEC 27 1920 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to Dec. 26, 1920, that I last saw h[illegible] alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 12:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological Findings

(Signed) H. Hedonius M. D.

12/27/20 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	12/27 1920
20 UNDERTAKER	ADDRESS
Jack Lewis	1417 E Balto

N. B.—Write plainly. All information should be carefully supplied. Any that it may be properly classified. Exact statements CAUSE OF DEATH in plain terms, so that it s on back of certificates. TION is very important. See instructions on b

Spec.—8-24-14—M. & T.—2000 Bks.

0049279 HEALTH DEPARTMENT—CITY OF BALTIMORE 0049279

CERTIFICATE OF DEATH. 151

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 William St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Lee Mandley

(Residence in Baltimore: No. 1513 William St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, December (Month) 23 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert L. Mandley.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Laura Duck.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert L. Mandley

(Address) 1513 William St.

15-

Filed DEC 27 1920, 191... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1920, to Dec 25 1920, that I saw h[illegible] alive on Dec 25 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(a) Fracture of skull

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) X

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Dec 26, 1920 (Address) 1340 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 2 ds. In the State — yrs. — mos. 2 ds.

Where was disease contracted, if not at place of death? X

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Dec 27, 1920

20-UNDERTAKER William H Snyder

ADDRESS 3624 Ash Av

N. B.—Every item of DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH must be stated. See instructions on back of certificate. Be particular and write plainly. All questions should be answered, as every item is important.

D 49280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49280

CERTIFICATE OF DEATH.

64

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 545 Dolphin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Henry Goldstrough

(Residence in Baltimore: No. 545 Dolphin St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, November (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 023
(b) General nature of industry, business, or establishment in which employed (or employer)..... Teamster

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benjamin Goldstrough

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harman Goldstrough

(Address) 545 Dolphin St.

15- DEC 27 1920

Dated....., 191.....

ROBERT N KRAUTER

Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(10 mins.)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diabetis Sclerosis
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hendessy M. D.
(Coroner)
Dec 26, 1920 (Address) 2802 Eastern ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec. 27, 1920

20-UNDERTAKER Samuel F. Hemsley — ADDRESS, 518 Riddle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Leon Basij

D49281 HEALTH DEPARTMENT—CITY OF BALTIMORE D49281

CERTIFICATE OF DEATH. 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1042 E Lombard ST.: 3 WARD) REGISTERED No. C

2-FULL NAME Leon Basij

(Residence in Baltimore: No. 1042 E Lombard St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Basij Sister

(Address) 1042 Bank St

15- DEC 27 1920 ROBERT F KRAUTER Burial Permit Clerk

(Undertaker) ....., 191....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia accidental
Inhalation of Illuminating gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Tyler Coroner Key M. D.

Dec 25 1920 (Address) 1404 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Dec 27 1920
20-UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D49282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49282

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1602 W Fayette ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Vaughan

(Residence in Baltimore: No. 1602 W Fayette St.: 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
F	W.	Widow

6-DATE OF BIRTH, Unknown (Month), (Day) 1850 (Year)

7-AGE, 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS:

10-NAME OF FATHER, John McLaughlin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary McLaughlin

(Address) 1602 W Lanvale & Street

15-

Filed....., 191.....

DEC 27 1920

Registrar.

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1919, to Dec 25 1920, that I saw h— alive on Dec 25 1920, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 10 ds.

(Signed) Edward V Kendall M. D.

Dec 27, 1920 (Address) 24 W Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	Dec 28 1920

20-UNDERTAKER	ADDRESS
John Howard Low	901 Hollins St

Remarks

No hemorrhage. Primary atero sclerosis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D49283

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2704 W Balto ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Brown

(a) RESIDENCE. No. 2704 W. Balto ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 13, 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shipwright

(b) General nature of industry, business, or establishment in which employed (or employer) — 088

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo. Smith

(Address) 2704 W Balto St

15 Filed DEC 27 1920 ROBERT B. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 24, 1920, that I last saw him alive on Dec 24, 1920, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Mad Neill, M. D.

12/26 1920 (Address) 108 N Bulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westend Cem	Dec 27, 1920

20 UNDERTAKER John J Leaman & Son — ADDRESS 907 Hollins St

N. B.—[illegible] mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2000 E. Preston ST.: 8 WARD)

2-FULL NAME Samuel B. Cacy

(a) RESIDENCE. No. 2000 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~
HUSBAND of (or) ~~WIFE of~~ Benena Cacy

6 DATE OF BIRTH (month, day, and year) Dec 1st 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Corp

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anns Co
(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Cacy

11 BIRTHPLACE OF FATHER (city or town) Queen Anns Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Elmer R Cacy
(Address) 2000 E Preston st

15 Filed DEC 27 1920 19

ROBERT B KRAUSER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 25 1920, that I last saw him alive on Dec 24 1920, and that death occurred, on the date stated above, at 1255 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Janet Fraser, M. D.

12/26 1920 (Address) 18 vs N Front St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 28th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE legibly. All information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D49285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2637 Guilford Ave St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stegman

(a) RESIDENCE. No. 2637 Guilford Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a [redacted] HUSBAND of Anna S. Stegman

6 DATE OF BIRTH (month, day, and year) Dec 6th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Stegman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anna S. Stegman

(Address) 2637 Guilford Ave

15 DEC 27 1920 ROBERT F. LEACH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19.., to Dec 24, 1920, that I last saw h[redacted] alive on Dec 24, 1920, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Fotsch M. D.

Dec 26 1920 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn. DATE OF BURIAL 12/27 1920

20 UNDERTAKER Wm Chas A. G. Rohde ADDRESS 600 N. Arlington Ave

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D49286 HEALTH DEPARTMENT—CITY OF BALTIMORE D49286

CERTIFICATE OF DEATH.

REGISTERED No. C 80

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2244 Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy Upshur

(Residence in Baltimore: No. 224 N. Bruce St. 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Femal	Colored	Widow

6-DATE OF BIRTH, ...March...., 1..... (Month) (Day) (Year)

7-AGE, ...29....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer)..... Privat Family

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Upshur

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nancy Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Dillon

(Address) 224 N. Bruce St

15- Filed DEC 27 1920 ROBERT A KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....Inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) James H Pullen M. D. (Coroner.)

Dec 28 1920 (Address) 1101 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Dec 29, 1920
20-UNDERTAKER	ADDRESS
Bernard Leland	Lehmden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D49287 HEALTH DEPARTMENT—CITY OF BALTIMORE D49287

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 John ST.: 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Randolph Berkeley

(a) RESIDENCE. NO. 1423 John ST., 11 WARD. Norfolk Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 43 yrs. 0 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Primrose Cassell Berkeley

6 DATE OF BIRTH (month, day, and year) Nov-30-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	0	26	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) For Le—

(c) Name of employer American Tobacco Co. Farmville

9 BIRTHPLACE (city or town) (State or country) Farmville Virginia

PARENTS

10 NAME OF FATHER Wm. R. Berkeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Farmville Virginia

12 MAIDEN NAME OF MOTHER Ellen Hilsea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Farmville Virginia

14 Informant Mrs Primrose C. Berkeley (wife)

(Address) 1423 Johnst

15 DEC 27 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec — 1920, to Dec 26 1920, that I last saw him alive on Dec 24— 1920, and that death occurred, on the date stated above, at 7 45 P— m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis —

(duration) Some yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage 15 minutes —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Norfolk Va

Did an operation precede death? No — Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Phy. Exam — Sputum Examined —

(Signed) — M. D.

Dec 27 1920 (Address) 132 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va

DATE OF BURIAL Dec 27 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WHERE PERSONS ARE ATTENDED IN LAST ILLNESS, information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Omission of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6049288 6049288 152 6049288

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 E. Hamilton ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lee Schulte Jr.

(Residence in Baltimore: No. 4 E. Hamilton ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 15 (Day), 1926 (Year)

7-AGE, ... yrs. 1 mos. 5 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Edward Lee Schulte

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary Ida Bohaman

13-BIRTHPLACE OF MOTHER (State or Country), St Mary's Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Schulte

(Address) 4 E Hamilton Ave

15- ROBERT B KRAUTER

Filed DEC 27 1920 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920, to Dec 26 1920, that I saw h[illegible] alive on Dec 26 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Congestion of Pneumonia

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Exhaustion + Toxemia

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Chas [illegible] M. D.

Dec 26, 1920 (Address) 47 E Hamilton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, LOUDON PARK. DATE OF BURIAL, DEC 27 1920

20-UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

N. B.—Every item of information should be carefully sought for, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Catalina Ground WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hill Jr

(a) RESIDENCE. No. 605 Catalina Ground WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Hill Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hugh C Hill

(Address) Alleyday Ave Towson

15 DEC 27 1920 ROBERT E KRAUTER Registrar

Dr Thomas 1228 N Caroline

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Dec 24, 1920, that I last saw h[illegible] alive on Dec 24, 1920, and that death occurred, on the date stated above, at 12 6 m.

The CAUSE OF DEATH* was as follows:

Fractured Prostate
Cystitis Sclerosis
Endocarditis, abortive
Stenosis (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. P. Thomas M. D.

(Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem't	Dec. 27 1920

20 UNDERTAKER Wm Leach 512 E Baltimore

ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49290

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Union ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Sachse.

(a) RESIDENCE. No. 1513 Union ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E Sachse

6 DATE OF BIRTH (month, day, and year) June 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66.	6m 2 25		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter 50
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Sachse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wilhelmina Albright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary E. Sachse
(Address) 1513 Union ave.

15 FILED DEC 27 1920 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 at ....., 19 20, to Dec 24 - 20, 19 20, that I last saw him alive on Dec 24 - 20, 19 20, and that death occurred, on the date stated above, at 3.00 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) ....yrs. 2 mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) B. A. Lillard, M. D.

12/26 1920 (Address) 1527 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 28 1920
20 UNDERTAKER	ADDRESS
Wm. Cook & Son	502 E Baltimore

N. B.—WRITE PLAINLY, WITH INK. All items should be stated. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D 49291

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D 49291

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1751 Hanover St. ST. ..... WARD) 23

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (John) Anna Hornberger.

(Residence in Baltimore: No. 1751 Hanover St. St.: 22 yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female.	White.	Married.

6-DATE OF BIRTH: June, 10, 1856 (Month) (Day), 1 (Year)

7-AGE: 64 yrs. 6 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None. 0
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Harford Co. Md.

PARENTS

10-NAME OF FATHER: John A. Kyle.

11-BIRTHPLACE OF FATHER (State or country): Pennsylvania.

12-MAIDEN NAME OF MOTHER: Mary Curry.

13-BIRTHPLACE OF MOTHER (State or country): Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanders Hornberger. (Husband)

(Address) 1751 Hanover St.

15- Filed DEC 27 1920, 191 ROBERT J. KRAUSE Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 25th. 1920. (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 21st. 1920, 191, to Dec, 25th. 1920, 191, that I saw her alive on Dec, 25th. 1920, 191, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Exhaustion.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto C. Reinhardt M. D.

Dec 25th, 1920. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Upper Falls Baltimo — DATE OF BURIAL: Dec 28 1920

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

049292

049292

CERTIFICATE OF DEATH.

30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brinson

(a) RESIDENCE. NO. 1737 Ashland Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 25.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Oscar Brinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Catherine Brinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J H H Records
(Address)

15 Filed DEC 27 1920 19 ROBERT P. LEAUTER Registrar
Burial Permit 6167

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 18, 1920, to Dec 26, 1920, that I last saw him alive on Dec 26, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home address

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W D Davison, M. D.

, 19 (Address) J H H Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmtry	Dec 28 1920
20 UNDERTAKER Mrs Robt A Elliott	ADDRESS 1725 Eastend Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49293

CERTIFICATE OF DEATH.

103

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1747 Carlyle Place ST.; 8 WARD)

2-FULL NAME James Young

(a) RESIDENCE. No. 1747 Carlyle Place ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec? 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Ned Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Indiana Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lillian Courtney
(Address) 1747 Carlyle st

15 Filed ... 19 ... Registrar

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from December 25 1920, to December 27 1920, that I last saw him alive on December 26 1920, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
& Convulsions

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Leigh W Kennard, M. D.

Dec 28 1920 (Address) 708 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blackstone Va	Dec 27 1920
20 UNDERTAKER	ADDRESS 1725
Mrs Rose a Elliott	ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S address should be stated EXACTLY. PHYSICIAN'S name should be signed. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 49294 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49294

91

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 912 Green Willow Court St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie O. Jackson

(Residence in Baltimore: No. 912 Green Willow Court St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, March 15, 1920.
(Month) (Day) (Year)

7-AGE, 9 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... home

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Clarence Jackson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Marie Lovelace

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Jackson

(Address) 912 Green Willow Ct

15-
Filed DEC 27 1920, 191.....
ROBERT A. CRAWFORD
Registrar.
Burial Permit Oleet

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. D. Kennedy M. D.
(Coroner)

Dec 26, 1920 (Address) 2802 Eastmanor Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 27 1920
20-UNDERTAKER Denis Taylor	ADDRESS 916 Pa Ave

WRITE PLAINLY. PENCIL MARKS ARE NOT ACCEPTABLE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49295

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D49295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 953 Pennsylvania ave ST.; 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Spriggs

(a) RESIDENCE. No. 953 Penn. ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH LEAD PENCIL. PHYSICIAN should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Crachen

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Landers

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant [redacted] Daniel Easton
(Address) 966 Ca ave

15 Filed DEC 27 1920 ROBERT P. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25- 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-24- 1920, to 12-25- 1920

that I last saw h[illegible] alive on 12-24- 1920

and that death occurred, on the date stated above, at 8,15 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Independent
(duration) yrs. mes. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Hamill, M. D.

12-25 1920 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 27 1920
20 UNDERTAKER	ADDRESS
David Easton	966 Ca ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 49296

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1361 Streeter ST.: 15 WARD)

2-FULL NAME Carrol Wayne Watkins

(a) RESIDENCE. No. 1361 Streeter ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Nov 21, 1920

7 AGE — Years: — Months: 1 Days: 5 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): 1361 Streeter

PARENTS

10 NAME OF FATHER: Carrol Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Lelia Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co

14 Informant: Lelia Watkins (Address) 1361 Streeter

15 Filed DEC 27 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1920, to Dec 26, 1920, that I last saw h... alive on Dec 26, 1920, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 7 1/2 mos

Fortes.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Waylis, M. D.

Dec 27 1920 (Address) 1309 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters

DATE OF BURIAL: Dec 29, 1920

20 UNDERTAKER: JAMES H. DENNIS

ADDRESS: 1309 PRESTMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049297

HEALTH DEPARTMENT—CITY OF BALTIMORE

049297

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ~~St.~~ 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M. Crell

(a) RESIDENCE. No. 528 N. Robeston St. City. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Married George N Crell

6 DATE OF BIRTH (month, day, and year) Feb 11 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Roth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Richter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed DEC 27 1920 ROBERT B. [illegible]

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-25 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920 to Dec 25-, 1920, that I last saw her alive on Dec 25-, 1920, and that death occurred, on the date stated above, at 7-0 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral disease

Not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward C. Davidson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 28 1920
20 UNDERTAKER	ADDRESS
Kendall Dyer Gleason	378 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Blks.

D49298 HEALTH DEPARTMENT—CITY OF BALTIMORE D49298

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 579 S. Luzerne Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A Seyler

(Residence in Baltimore: No. 579 S. Luzerne St. St.; 53 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... September 28, 1867
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Seyler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Frederick Seyler

(Address)..... 579 S. Luzerne St.

15-

Filed ..... DEC 27 1920 ..... 191.....

ROBERT B. LOUDER
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 25th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec. 25 1920, that I saw him alive on Dec. 24 1920, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Coma

..... (Duration) ..... yrs. ..... mos. 2 ..... ds.

(Signed) Charles F. Key M. D.

12/27/20, 191... (Address) 408 S. Bank Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pat Carroll Cem	Dec. 27, 1920

20-UNDERTAKER	ADDRESS
Lee & Cook	1007 N. Howard

N.B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049299

HEALTH DEPARTMENT—CITY OF BALTIMORE

049299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1116 Chiney ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Wallace

(Residence in Baltimore: No. 1116 China St.; 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... Unknown ....., 18.6.. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
60 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook on ..... yl
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Steamer Eng. .....

9-BIRTHPLACE, (State or Country) Calvert County Md.

PARENTS.

10-NAME OF FATHER Joseph Wallace

11-BIRTHPLACE OF FATHER (State or Country) Calvert County Md

12-MAIDEN NAME OF MOTHER Drusella Wells

13-BIRTHPLACE OF MOTHER (State or Country) Calvert County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... James Wallace (Brother)

(Address) 508 Leadenhall St.

15- DEC 27 1920 Filed ....., 191.. BUREAU OF VITAL STATISTICS Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. ..... 21 ....., 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13 1920, to Dec. 21 1920, that I saw h.. alive on Dec. 21 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

..... Mitral Insufficiency .....

.....

..... (Duration) ..1.. yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. T. Robertson ..... M. D.

....., 191... (Address) ..... 1116 E. Chiney .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Yorkers Run Calvert Co Md	Dec. 24, 1920
20-UNDERTAKER	ADDRESS
J. W. Broumdell & Son	1084 W. Pratt St

Bureau Room Porter

WRITE PLAINLY.—Every item of information should be carefully supplied. ACE should be stated correctly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Baby Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049300

1049300

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Jackson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Female infant in utero

(Residence in Baltimore: No. 1630 Jackson St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Mulatto	

6-DATE OF BIRTH, 12 (Month) 26 (Day), 1920 (Year)

7-AGE, ——— yrs. ... mos. ... ds. If LESS than 1 day, 1 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: a Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

1630 Jackson St

PARENTS.

10-NAME OF FATHER, Harley H. Brown

11-BIRTHPLACE OF FATHER (State or Country), Java

12-MAIDEN NAME OF MOTHER Jessie Baxter

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harley H. Brown

(Address) 1630 Jackson St

15- DEC 27 1920 ROBERT B CRAUTER

Filed ..... 191.. Burial Permit Clerk.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, 12 (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-26-1920, to 12-26-1920, that I saw h[illegible] alive on 12-26-1920, and that death occurred, on the date stated above, at 12 Mid m.

The CAUSE OF DEATH* was as follows:

Immaturity Birth

Infant 1 months in utero

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) F. A. Sheppard M. D.

12-27-1920 (Address) 422 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ———

Former or usual residence ———

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	Dec. 27, 1920
20-UNDERTAKER	ADDRESS
F. S. Norman & Son	Hanover st

Every item of information should be carefully supplied. AGE should be stated EXACTLY in all cases. Exact statement of OCCUPATION necessary to properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Beinschla

049301 HEALTH DEPARTMENT—CITY OF BALTIMORE 049301

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 Fairoak ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Beinschla

(Residence in Baltimore: No. 107 Fairoak ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 8 (Day), 1861 (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 1 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry F Beinschla

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Catherine Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Beinschla

(Address) 107 Fair Oaks ave

15- Filed DEC 27 1920, 191... ROBERT B KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Dec 25 1920, that I saw him alive on Dec 25 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) ....yrs. 6 mos. ....ds.

(Signed) Jenny L Lowe M. D.

Dec 26, 1920 (Address) 827 Harford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Dec 28, 1920
20-UNDERTAKER	ADDRESS, 039
E Schlosman Son	Fairmount

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49302

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes' Hospital ST.: 25 WARD) x 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lou Graham

(a) RESIDENCE. NO..... ST..... WARD. Dawson Texas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ougle

6 DATE OF BIRTH (month, day, and year) June 6 - 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dawson Texas

PARENTS

10 NAME OF FATHER Calvin Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Kate Clemons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Mrs J. Graham

(Address) Dawson Texas

Filed Dec 28 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 19 20

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Dec. 26 1920, that I last saw her alive on Dec. 26 1920, and that death occurred, on the date stated above, at 7:15 p. m.

The CAUSE OF DEATH* was as follows:

Dermoid cyst of mediastinum and right lung. Operation 3 days ago. Portion excision

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lober Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12-23-20.

Was there an autopsy? No

What test confirmed diagnosis? Operation & microscopic

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dawson Texas DATE OF BURIAL Dec 28 1920

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

MAKE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D49303 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049303

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Park ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Euker

(a) RESIDENCE. No. 1417 Park ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Euker

6 DATE OF BIRTH (month, day, and year) July 10, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Henry Cracke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Mahler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eleanor E. Smith
(Address) 1417 Park ave

15 DEC 27 1920 REGISTERED Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 26, 1920, that I last saw h[er] alive on Dec 26, 1920, and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Coma due to Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McIlhenny M. D.

. 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Dec 27 1920

20 UNDERTAKER ADDRESS

Chas Whitehead 120 N. Fayette

THIS IS A PERMANENT RECORD, AND MUST BE WRITTEN PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49304 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49304

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 N. Bentalou ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert D. Carter Jr.

(a) RESIDENCE. No. 1649 N. Bentalou ST., 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie M. Flohr Carter

6 DATE OF BIRTH (month, day, and year) April 10-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Adjuster

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Robert D. Carter Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Est. S. Buckhout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Rob H. Carley Son
(Address) 1600 N. Calvert St.

15 Filed Dec 27 1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920, to Dec 26, 1920, that I last saw h.. alive on Dec 25, 1920, and that death occurred, on the date stated above, at 4.50P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Ferguson

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grover T. Thayer, M. D.

Dec 27 1920 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 29 1920
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W North Ave

THIS IS A LEGAL DOCUMENT—PHYSICIANS ... should state ... should be stated EXACTLY, carefully supplied. AGE should ... it may be properly classified. Exact statement of OCCUPATION ... on back of certificates. TION is very important. See instructions on back ... CAUSE OF DEATH in plain terms, so that ... WITH UNFADING INK—THE

D.49305 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lunch room Packing House 15 ST.: 64 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D Schaul

(Residence in Baltimore: No. 1726 W Saratoga St.) St. (yrs. 40 mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Sngl

6-DATE OF BIRTH, May 23, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. 7 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John D Schaul

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Laura Ward

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Block Schaul

(Address) 1434 N Gilmor St

15-

DEC 27 1920

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Gay McKay M. D.
(Coroner)

12/25, 1920 (Address) 1820 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 28, 1920

20-UNDERTAKER F D Kappert — ADDRESS 2236 Eutaw

IMPORTANT—THIS IS A PERMANENT RECORD AND SHOULD BE WRITTEN WITH UNFADING INK. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Rec. 6-9-19—H. P. Co.—1000 Bks.

D.49306 ✓D.49306

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2316 Etting ST.: 14 WARD)

2-FULL NAME Infant of Charles & Emma Speas

(a) RESIDENCE. NO. 2316 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 25/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath (State or country) Md

PARENTS

10 NAME OF FATHER Charles Speas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma M. Shuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Speas (Address) 2316 Etting St

15 Filed DEC 27 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1920, to Dec 27, 1920, that I last saw h[illegible] alive on Dec 26, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 mo's)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) William Frey, M. D.

12/27, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPIT[illegible]	ADDRESS
20 UNDERTAKER Per. Wm. E. WOODALL	DEC 27 1920

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49307 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49307

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Davis

(a) RESIDENCE. No. 209 N. Montford Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Gradison Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Margaret Brinkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant R. Liddall. (Address)

15 Filed DEC 27 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to Dec, 23, 1920, that I last saw h[illegible] alive on Dec, 22, 1920, and that death occurred, on the date stated above, at 4 40 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) E. L. Stone, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. Woodall.

DEC 24 1920

D.149308 HEALTH DEPARTMENT---CITY OF BALTIMORE D.149308

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 79

CITY OF BALTIMORE: (No. 3001 Huntingdon St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Eliza J. Watson

(Residence in Baltimore: No. 3001 Huntington Ave St.; 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F. | 4-COLOR OR RACE W | 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Sept 1 (Month) 1858 (Day) 1920 (Year)

7-AGE 62 yrs. 4 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Va

PARENTS

10-NAME OF FATHER Benj. Hardy

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Eliza Mary Bate

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Watson

(Address) 3001 Huntington

15- Dec 29 1920 Robert P. Harrison, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 12/28 (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/23, 1920, to, 12/28 1920, that I saw h[illegible] alive on 12/24 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 5 yrs. 4 mos. ds.

Contributory (SECONDARY) Chronic Cystitis

(Duration) 7 yrs. mos. ds.

(Signed) Henry T. Cassidy M. D.

12/28, 1920 [Address] Calvert St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Shamador Md | DATE OF BURIAL Dec 29, 1920

20-UNDERTAKER Chenowith & Chestnut | ADDRESS

D.49309 Marrune D.49309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 857 E Pratt ST. 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Marrune

(Residence in Baltimore: No. 857 E Pratt St Sr; 6 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1856 (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Printer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry A. Smelley

(Address) 1800 N Charles St

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy also (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy also (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Henry A. Smelley M. D.
(Coroner.)
Dec 27 1920 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents Cem	Dec 28 1920
20-UNDERTAKER	ADDRESS
Kendall & Keyser & Son	37 S Cam

important. See instructions on back.

FEB 1 1921

ec.—6-9-19—H. P. Co.—1000 Bks.

D.49310 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.49310

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Hudson St.; 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Sniss

(a) RESIDENCE. No. 3031 Hudson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sens

6 DATE OF BIRTH (month, day, and year) Unknown 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	76.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Fernand Russy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Joseph Sens (Address) 3031 Hudson

15 Filed OCT 27 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1920, to Dec 25 1920, that I last saw h.. alive on Dec 25 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) F. F. Rhynda, M. D.

12-29 1920 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 28 1920
20 UNDERTAKER	ADDRESS
Randall Hopper & Son	37 E Lanvale

ec.—6-9-19—H. P. Co.—1000 Bks.

0.49311 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49311

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. Md. General Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Theresa Zimmer

(a) RESIDENCE. No. 1418 Cooksie ST., VA WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W. | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? ? ?

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years 32 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Zimmer (Address) 1418 Cooksie Ave

15 Filed 27 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24 1920, to Dec. 24 1920, that I last saw her alive on Dec. 24 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Labora

(Signed) Dr. Philibert Artigiani M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/27 19 20

UNDERTAKER F. J. Talbert

ADDRESS 1318 E. [illegible]

149312 HEALTH DEPARTMENT—CITY OF BALTIMORE 149312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Camden Stations Cafe ST.) WARD)

REGISTERED No. C 279

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas E. Schwarzenbach Jr

(Residence in Baltimore: No. 507 Seward Square W. B. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 4 (Day), 1878 (Year)

7-AGE, 42 yrs. 3 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Schwarzenbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marguite Humber

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Schwarzenbach

(Address) 1235 Columbia Ave

15- DEC 28 1920 Filed ....., 191... ROBERT P KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ ..... ~~topsy or in~~quiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D. (Coroner.)

12-27, 1920 (Address) 112 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington Co.

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, 12/29/1920

20-UNDERTAKER Thos Mc Jno W Teufel ADDRESS 801 W Fayette

ec.—6-9-19—B. P. Co.—1000 Bks.

049313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 049313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 Canal St ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Webb

(a) RESIDENCE. No. 339 Canal st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE: Years 39; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer E & Dorsey

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Daniel Easton

(Address) 916 Fa ave

15 DEC 28 1920 ROBERT A. REAUTER Registrar

Burial Permit 01618

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Dec 24, 1920, that I last saw her alive on Dec 23, 1920, and that death occurred, on the date stated above, at 110 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Otitis Mycotica

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinique

(Signed) Chas Plaut M. D.

(Address) 1504 McCulloh st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Dec 28 1920
20 UNDERTAKER Daniel Easton	ADDRESS 916 Fa ave

Spec.—8-24-14—M. & T.—2000 Bks.

Ruth Z. Green

HEALTH DEPARTMENT—CITY OF BALTIMORE

2149314

49314

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Penna. Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Z. Green

(Residence in Baltimore: No. 1008 Penna Ave St.; 16 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH ..... (Month) May (Day) 19th, 1904 (Year)

7-AGE, 16 yrs. 7 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Do

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wm H. Daily

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary A. Green

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Green

(Address) 1008 Penna Ave, City

15- Filed DEC 28 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to DEC 27th 1920, that I saw h[illegible] alive on Dec 27th 1920, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary T. B.

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Carbaugh M. D.

12/27, 1920 (Address) 1800 Linden Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Dec 30, 1920

20-UNDERTAKER Daniel Easton

ADDRESS 916 Fa ave

ec.—6-9-19—H. P. Co.—1000 Bks.

Mary Judge

49315 HEALTH DEPARTMENT—CITY OF BALTIMORE 49315

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. St Vincent's Infant 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Judge

(a) RESIDENCE. No. St Vincent's Asy ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 92

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant D. H. Mathers

(Address) St. Vincents Infant Asylum

15 DEC 28 1920 ROBERT I KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Dec 25, 1920, that I last saw her alive on Dec 24, 1920, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Clendenin M. D.

(Address) 1501 McCulloh Dec 27, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Dec 28

20 UNDERTAKER M Fahey & Son ADDRESS 1824 N Nort

ec.—6-9-19—H. P. Co.—1000 Bks.

1049316 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049316

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

ITY OF BALTIMORE: (No. 802 Bevan ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph West

(a) RESIDENCE. NO. 802 Bevan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE Col

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Janey West

6 DATE OF BIRTH (month, day, and year) Apr, 18, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Cement Work

(c) Name of employer Howard Della

9 BIRTHPLACE (city or town) Essex Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Felling West

11 BIRTHPLACE OF FATHER (city or town) Essex Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Janey Sparks

13 BIRTHPLACE OF MOTHER (city or town) Essex Co.
(State or country) Virginia

14 Informant Janey West
(Address) 802 Bevan St

15 FILED DEC 28 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 25, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec, 4, 1920, to Dec, 25, 1920, that I last saw h.. alive on Dec 25, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. 1 moa. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Swanelin, M. D.

12/27, 19 (Address) 1211 See 16

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct.	Dec 27 1920
20 UNDERTAKER	ADDRESS
L. W. L. Brown & Son	10 W. Monty

...—6-9-19—H. P. Co.—1000 Bks.

1049317 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049317

CERTIFICATE OF DEATH.

109 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No St. Joseph's Hosp. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Stolpp

(a) RESIDENCE. NO. 306 S. Bouldin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Stolpp.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 Months about Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Dolch.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm Trasmer

(Address) 306 S Bouldin

15 Filed DEC 28 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1920, to Dec. 25, 1920, that I last saw her alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronnshaw, M. D.

12-25-1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Evangelical

DATE OF BURIAL: Dec 28 1920

20 UNDERTAKER: William Gallagher

ADDRESS: 1648 Eastern

Sec.—6-9-19—H. P. Co.—1000 Bks.

049318

HEALTH DEPARTMENT—CITY OF BALTIMORE

049318

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH 1933 E Monument St

CITY OF BALTIMORE: (No. 1933 E. Monument ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Robert Klingenstein Jr.

(a) RESIDENCE. NO. 1933 E. Monument St. ST., 7th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. 5 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Howard Robert Klingenstein

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Theresa Leid

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant. Howard R. Klingenstein (Address) 1933 E Mounument st

15 Filed DEC 28 1920 19 ROBERT I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to Dec. 26, 1920, that I last saw him alive on Dec. 26, 1920, and that death occurred, on the date stated above, at 2.10 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? No abnormal test

(Signed) A.D. Macdonald. M. D.

12/28/1920 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 28 1920
20 UNDERTAKER	ADDRESS
Robt G Turner Son	1402 N Broadway

D 49319

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 E. Hamburg ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dolan

(a) RESIDENCE. No. 36 E. Hamburg ST., WARD. 24

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Dolan

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Reynolds

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant John Dolan (Address) 36 E Hamburg

15 Filed DEC 28 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 24, 1920, that I last saw her alive on Dec 27, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Intestinal Paralysis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Hammerbacher, M. D.

(Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	Dec 29 1920
20 UNDERTAKER	ADDRESS
F. J. Tunney & Son	763 Hollins

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to intestinal carcinoma

Margaret Mc Cuskar

...—6-9-19—H. P. Co.—1000 Bks.

049320

HEALTH DEPARTMENT—CITY OF BALTIMORE

049320

CERTIFICATE OF DEATH.

1919 91

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mgt Mc Cuskar

(a) RESIDENCE. No. 407 N Fulton St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of not any

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	93	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer not any

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Not known

14 Informant Miss M. J. Hudson

(Address) 407 N Fulton

15 Filed Dec 26, 20 ROBERT N. KRAUTER Registrar

DEC 28 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1920, to Dec 26, 1920, that I last saw her alive on Dec 26, 1920, and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - bronchial

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 407 N. Fulton St.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical exam.

(Signed) Paul E Brown, M. D.

12-7-1920 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/31/20
20 UNDERTAKER	ADDRESS
George A Tinley Sons	Fulton & Fayette

D 49321 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49321

150

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2404 Wilkins Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence E Libley

(Residence in Baltimore: No. 2404 Wilkins Ave St.: yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Sing'l

6-DATE OF BIRTH, Oct 14, 1918
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)..... Child

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles Libley

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Cedelia Turner

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cedelia Libley

(Address) 2404 Wilkins Ave

15- Filed DEC 28 1920 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Double Lobular

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) yrs. mos. ds.

(Signed) H. M. Fuller M. D.
(Coroner.)

Dec 28 1920 (Address) 1 W E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Dec 28, 1920

20-UNDERTAKER Geo. Schwab & Bro ADDRESS 1121 Eutaw Ave

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Blks.

Shapiro

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49322 D49322

CERTIFICATE OF DEATH.

X 74

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Shapiro

(Residence in Baltimore: No. Norfolk Va St. 7 yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant 45
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Balto X

15-

Filed..... ROBERT J. KRAUTER Registrar.

DEC 28 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1920, to Dec 26 1920, that I saw h[illegible] alive on Dec 26 1920, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY Operation
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.

12-26-20, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence Norfolk Va

19-PLACE OF BURIAL OR REMOVAL, Workmen Circle Mt. Carmel

DATE OF BURIAL, Dec 28, 1920

20-UNDERTAKER Jack Lewis,

ADDRESS 1411 E. Balto

Little

D49323 HEALTH DEPARTMENT—CITY OF BALTIMORE D49323

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Glover Dale Road 2925 St.; 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Little

(Residence in Baltimore: No. 2543 Florence st St.; (yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	C.	Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE. 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): Bkr

9-BIRTHPLACE, (State or Country), U. S.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ollie Little

(Address) 2543 Florence st

15-

Filed DEC 28 1920 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Powder Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Thurmon M. D. (Coroner.)

Dec 28 1920 (Address) 532 Reliance

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cmtry	Dec 28, 1920
20-UNDERTAKER Wm Robt Elliott	ADDRESS 1725 Ashland Ave

important. See instructions on back

Burial Permit

D49324

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D49324

64

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2931 St. Paul St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Kunkel

(Residence in Baltimore: No. 2931 St. Paul St.: 65 yrs. -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6 DATE OF BIRTH February (Month) 24 (Day), 1842 (Year)

7 AGE 78 yrs. 10 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cigar Mfg.
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: August Kunkel

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: ---------- Gehrman

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Katharine M. Wells

(Address) 2931 St. Paul St.

15 Filed DEC 28 1920, 191.... ROBERT A KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. (Month) 26 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to Dec. 26, 1920, that I saw h[illegible] alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

Probably for 6 years (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Cerebral Apoplexy 18 hours (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. H. Hartman M. D.

Dec. 28, 1920 (Address) 2314 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL 12/28, 1920

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS 805 N. Calvert

This is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 049325

049325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1372 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James R. Rose (If not known, St.; 40 yrs., — mos. — ds.)

Residence in Baltimore: No. 1372 Mc Culloh

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar. 28, 1852 (Month) (Day) (Year)

7-AGE, 68 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Retired (gd)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Ruffins Rose

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Louise Meriwether

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Rose (Wife)

(Address) 1372 McCulloh Stett

15- Filed DEC 28 1920, 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 18 1920, to Dec. 27 1920, that I saw him alive on Dec. 26 1920, and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 5 ds.

(Signed) C. E. Connor M. D.

Dec. 28, 1920 (Address) 215 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Dec. 30, 1920

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 E. Monument

Rec. 6-9-19—H. P. Co.—1000 Blks.

049326 HEALTH DEPARTMENT—CITY OF BALTIMORE 049326

CERTIFICATE OF DEATH. 137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie R Eaton

(a) RESIDENCE. NO. 2525 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R Eaton

6 DATE OF BIRTH (month, day, and year) Oct 6, 1888

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George R Eaton
(Address) 2525 E. Madison St

15 Filed DEC 28 1920 ROBERT B. QUANTER Registrar
Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Dec 26, 1920

that I last saw her alive on Dec 26, 1920

and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Puerperal Septicaemia

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 24, 1920

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl Coster, M. D.

, 19 (Address) M G H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oahlawn Cemetery

DATE OF BURIAL Dec 29 1920

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. Pratt ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

049327 049327

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Eaton

(a) RESIDENCE. NO. W. 9 H. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER George R. Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs. Emma Pistel

(Address) 2228 W. Fayette St

15 DEC 28 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1920, to Dec 25, 1920.

that I last saw him alive on Dec 25, 1920.

and that death occurred, on the date stated above, at 6.45 A.m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Patent Foramen ovale

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Phil. Ardigeanis, M. D.

, 19 (Address) M 9 H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Dec 29 1920

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North ave.

ec.—6-9-19—H. P. Co.—1000 Bks.

049328 HEALTH DEPARTMENT—CITY OF BALTIMORE 049328

41

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

ITY OF BALTIMORE: (No.) 647 Dover St (ST.) — (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ena Kummel.

(a) RESIDENCE. NO. 647 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Kummel

6 DATE OF BIRTH (month, day, and year): 12. 23. 1846.

7 AGE — Years: 74 — Months: — Days: 3. — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Kummel. (Address) 647 Dover St

15 Filed DEC 28 1920 ROBERT A KRAUTH Registrar

Burial Permit Oleth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1920, to Dec 27, 1920 that I last saw h[illegible] alive on Dec. 27, 1920 and that death occurred, on the date stated above, at 7 08 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Duodenum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Friedenwald M. D.

12-27, 19 (Address) 642 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec 30 1920

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Northst.

Dec.—6-9-19—H. P. Co.—1000 Bks.

49329 HEALTH DEPARTMENT—CITY OF BALTIMORE 49329

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Connie Hart

(a) RESIDENCE. NO. Volunteer of Amer. Hospital ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill hand

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cora Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed DEC 28 1920 ROBERT B REGISTRAR Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1920, to Dec. 27, 1920, that I last saw her alive on Dec. 27, 1920, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous broncho pneumonia

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Acute miliary tuberculosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. S. Fahnestock. M. D.

12-28-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec. 29 1920

20 UNDERTAKER William Cook

ADDRESS 502 E. Madison

049330 HEALTH DEPARTMENT—CITY OF BALTIMORE 049330

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH, CITY OF BALTIMORE (No. Eastern ave near Bayview St.: 3 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bussmann

(Residence in Baltimore: No. 1513 Lancaster St. St.; 1 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 15 (Day), 1849 (Year)

7-AGE, 73 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Iron Works

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Bussmann

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Annie Thomer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles J. Bussmann

(Address) 1513 Lancaster St

15-

Filed DEC 28 1920 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

Duncan

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Killed
by automobile

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otway Myers M. D.
(Coroner.)

12/28, 1920 (Address) 1606 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel.	Dec 29, 1920
20-UNDERTAKER Heuman Corse	ADDRESS 501 N Sw

Dec.—6-9-19—H. P. Co.—1000 Bks.

1049331 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1049331

CERTIFICATE OF DEATH. 19-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Siebert.

(a) RESIDENCE. NO. 1909 N. Register ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3-1918

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	2	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Georg Siebert.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Welter

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Hospital Records
(Address)

15 Filed DEC 28 1920 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1920, to Dec 27, 1920, that I last saw her alive on Dec 27, 1920, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Diptheria, tonsillar, pharyngeal & laryngeal.

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec 25.
Tracheotomy - at home.

Was there an autopsy? No Culture.

What test confirmed diagnosis?

(Signed) B Mackowan M. D.

(Address) Sydenham Hospital Dec. 28 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	12/28/20
20 UNDERTAKER	ADDRESS
Zickler & Zickler	1739 Eager St

ec.—6-9-19—H. P. Co.—1000 Bks.

D49332 HEALTH DEPARTMENT—CITY OF BALTIMORE D49332

CERTIFICATE OF DEATH.

91-081

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Morgan

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital

15 Filed DEC 28 1920, 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 19 20

17 I HEREBY CERTIFY, That I attended deceased from January 19 1891 to December 26, 19 20
that I last saw her alive on December 26, 19 20
and that death occurred, on the date stated above, at 11:15 A.m.
The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(Old cerebral thrombosis)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) B Sherman M. D.

12/27/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cem	Dec 28 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4038 Wolfe St

Dec.—6-9-19—H. P. Co.—1000 Bks.

1049333 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049333

CERTIFICATE OF DEATH. *61

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Scribner

(a) RESIDENCE. No. Della, Md ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Henry Scribner

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Lafferty

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed DEC 28 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 - 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 23 -, 1920, to Dec 27 -, 1920, that I last saw him alive on Dec 27 -, 1920, and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) - yrs. - mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture & smear

(Signed) W D Wilson. , M. D.

. 19 (Address) 720 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Della Baltimore.	12/29/20.
20 UNDERTAKER Custer Sons	ADDRESS Ellicott City

Spec.—8-24-14—M. & T.—2000 Bks.

D 49334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49334

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 N Fenwood ct ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Hulka

(Residence in Baltimore: No. 813 N Curley St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) Oct (Day) 8 (Year) 1860

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Thomas Hulka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mt Strom

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Hulka

(Address) 813 N Curley

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Dec 28 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Dec. 25, 1920, that I saw him alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene L. Cassagno M. D.

Dec. 27, 1920 (Address) 2314 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer

DATE OF BURIAL. Dec 29, 1920

20-UNDERTAKER Frank Brachton

ADDRESS 1906 Eastlake Ave

Spec.—5-19-13—M. & T.—500 Bks.

D.49335 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49335

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Brooklin ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen T. Naylor

(Residence in Baltimore: No. 3901 Brooklin ave. St.: 12 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Widower

6-DATE OF BIRTH, January 22nd, 1849
(Month) (Day) (Year)

7-AGE, 71 yrs. 11 mos. 6 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Coffee & Tea

9-BIRTHPLACE, (State or Country) Patuxent Anne Co Md

PARENTS.

10-NAME OF FATHER, Stephen T. Naylor

11-BIRTHPLACE OF FATHER (State or Country) Patuxent Anne Co Md

12-MAIDEN NAME OF MOTHER Lucretia Donaldson

13-BIRTHPLACE OF MOTHER (State or Country) Tomahawk Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Naylor

(Address) 3901 Brooklin Ave

15- DEC 28 1920, 191.. Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Dec 27 1920, that I saw h.. alive on Dec 27 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Cirrhosis of Liver

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. G. Queen M. D.

Dec 27, 1920 (Address) 3501 Garrison Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, Dec 29, 1920

20-UNDERTAKER George J. Smith

ADDRESS Fayette st

...c.—6-9-19—H. P. Co.—1000 Bks.

D.49336 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49336

CERTIFICATE OF DEATH. H5 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 N. Randall ST.) (23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret G. Shaw

(a) RESIDENCE. NO. 124 N. Randall ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~ Married Widowed, or ~~Divorced (write the word)~~: Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: John H. Shaw

6 DATE OF BIRTH (month, day, and year): Unknown 1850

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS

10 NAME OF FATHER: John Walton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Albert B. Wroten 124 N. Randall St.

15 Dated DEC 28 1920 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 28, 1920, that I last saw h... alive on Dec 28, 1920, and that death occurred, on the date stated above, at 9. 9. m.

The CAUSE OF DEATH* was as follows:

(Cehre) Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. F. Wheeler M. D.

12/28 1920 (Address) 1279 William

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Dec 30 1920

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

...TION is very important.

D49337 HEALTH DEPARTMENT—CITY OF BALTIMORE D49337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1143 Hull st. St.: 24 WARD) 28

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Michael J. Flynn.

(Residence in Baltimore: No. 1143 Hull st. St.; 29 yrs., 5 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 1st. 1891, 1 (Month) (Day) (Year)

7-AGE. 29 yrs. 5 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Patrick B. Flynn.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Annie Mulligan.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Flynn. (mother)

(Address) 1143 Hull st.

15- Robert E. Harrison,

Filed ....., 191.... Registrar.

DEC 28 1920 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Pulmonary Tuberculosis.
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Dec 29, 191... (Address) 16 W. Chas. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	Dec. 29, 1920
20-UNDERTAKER	ADDRESS
Margaret E. Flynn	1111 Light St.

ec.—6-9-19—H. P. Co.—1000 Bks.

20.49338

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49338

CERTIFICATE OF DEATH.

REGISTERED NO. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 18 WARD)

2-FULL NAME Sylvan Ahlfeldt

(a) RESIDENCE. No. Florence Courtlandt St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yet

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. Keiser

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Grace Ahlfeldt

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Husband (or Record) H. H.
(Address)

15 Filed ..., 19 ... Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 - 1920, to Dec 19 - 1920, that I last saw h... alive on Dec 19 - 1920, and that death occurred, on the date stated above, at 10:00 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) ... yrs. ... mos. 30 ds.

CONTRIBUTORY (Secondary) Marasmus (duration) ... yrs. ... mos. 30 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None

(Signed) W. Brown, M. D.

(Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health,

ADDRESS

JOHNS HOPKINS HOSPITAL DEC 2 1920

DEC 20 1920

Spec.—8-24-14—M. & T.—2000 Bks.

D.49339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49.339

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Jones

(Residence in Baltimore: No. ..... St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, February - 20, 1898
(Month) (Day) (Year)

7-AGE, 22 yrs. 9 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Richard Jones

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. S. Sweezy

(Address) Md State Penitentiary

15- Filed ....., 191.....

C28 1920 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December - 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February - 15 1918, to December - 17 1920, that I saw him alive on December - 16 1920, and that death occurred, on the date stated above, at 4 50 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Tuberculosis and Exhaustion

..... (Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary and Glandular Tuberculosis (Duration) 2 yrs. 10 mos. 2 ds.

(Signed) William J. Seward M. D.

Dec 17, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 11 mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 21 Second Ave. Newbern, N. C.

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health, ADDRESS DEC 3 1920

Per. Wm. E. WOODALL

D.49340 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 n Wolfe St. 8 WARD) REGISTERED No. C 156

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Williams Yates

(Residence in Baltimore: No. 1117 n. Wolfe St.; yrs., 4mo mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, ..., 1875.
(Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Gt

9-BIRTHPLACE, (State or Country), W. Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed DEC 28 1920, 191.....
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER Commissioner Health,	ADDRESS DEC 28 1920

Per Wm. F. Kuehn

Important.—Use indelible pencil.

D.49341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49341

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Unknown Town St. Alphonsus ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, Full term ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....mln.?

8-OCCUPATION: Probably few minutes old
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address).....

15- Robert F. Harrison, Burial Permit Clerk
Filed DEC 29 1920, 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 (Found Dead), 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due probably
to difficult birth
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration) ....yrs. ....mos. ....ds.

(Signed) W. J. Riley M. D.
(Coroner.)
Dec 27, 1920 (Address) 1657 Bens

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL, ... 192..
JOHNS HOPKINS HOSPITAL.	
20-UNDERTAKER Commissioner Health.	ADDRESS DEC 28 192

Per. Wm. E. WOODALL.

Important. See instructions on back

D.49342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49342

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Prancis Meekins.

(Residence in Baltimore: No. 809 Sterling St. life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

Single

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
M	W	

6-DATE OF BIRTH, Sept. (Month) 4 (Day), 1916 (Year)

7-AGE,	If LESS than 1 day,
4 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo F. Meekins.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Hanna Fuller

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George F. Meekins

(Address) 809 Sterling St.

15-

DEC 28 1920 Filed, 191, Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

Auto. Accident.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) G. C. Grade M. D.
(Coroner.)

12/27/, 191.. (Address) 1436 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery, Chase Md.	Dec 30 1920
20-UNDERTAKER	**ADDRESS**
Milton Davis	413 N Eden St

important. See instructions on back of Certificate.

ec.—6-9-19—H. P. Co.—1000 Bks.

D.49343 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49343

CERTIFICATE OF DEATH

Entire and Wilson sts. H5

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Hst ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Weinberg

(a) RESIDENCE. NO. Marlborough 53 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Weinberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johannah Conrad

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germy

14 Informant Wife
(Address) Marlborough

15 Filed DEC 28 1920, 19 Registrar
Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1920, to Dec-26-, 1920, that I last saw h alive on Dec-26-, 1920, and that death occurred, on the date stated above, at 11 P- m.

The CAUSE OF DEATH* was as follows:

Abdominal Malignant Dis-
(Cancer)
(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) General Exhaustion
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? Yes Date of

Was there an autopsy? No-

What test confirmed diagnosis? Operation

(Signed) Burton Brooks, M. D.

Dec 26 1920 (Address) 125 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bals. Hebrew — DATE OF BURIAL: Dec 29 1920

20 UNDERTAKER: Harris Sondheim — ADDRESS: 1[illegible] E Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49344 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49344

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1200 Bush ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie E. Borland

(a) RESIDENCE. No. 1200 Bush ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert E. Borland

6 DATE OF BIRTH (month, day, and year) Jan 1 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER James Homes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Robert E. Borland. (Address) 1200 Bush St.

15 Filed Robert P. Harrison, 19 Registrar

DEC 28 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Dec 27, 1920, that I last saw h[illegible] alive on Dec 25, 1920, and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Wesley Hoog, M. D.

12/28 1920 (Address) 129 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 29 20

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W Lombard

D.49345 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49345

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Helen Di Pasola

(Residence in Baltimore: No. 36 N. Albemarle St.; Yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. 2, 1913 (Month) (Day) (Year)

7-AGE, 7 yrs. mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balti

PARENTS.

10-NAME OF FATHER, Sam. Di Pola

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER C. Pafa

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sol. Cuero

(Address) 14 Albemarle

15- Dec 28 1920 Robert F. Harrison, ..., 191..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) clothes accidentally caught fire

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Gorsuch M. D. (Coroner.)

12-28, 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincents — DATE OF BURIAL, Dec. 29, 1920

20-UNDERTAKER William Cook — ADDRESS 502 E. North Ave

D.49346 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49346

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fond du Lac Embankment St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J. O'Donnell

(Residence in Baltimore: No. 1009 Union Av. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
46 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Police Officer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, W. A. J. O'Donnell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Sally Mulvihill

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. O'Donnell

(Address) 403 Warren Av.

15- DEC 28 1920 Robert P. Harrison, ..., 191.....
Burial Permit Clerk Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart dis. prob. valvular regurgitation

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) W. A. Riley M. D. (Coroner.)

Dec 28, 1920 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Catholic Cem	12/30, 1920
20-UNDERTAKER	ADDRESS
H. Poehlmann & Son	138 Eighth

ec.—6-9-19—H. P. Co.—1000 Bks.

049347

HEALTH DEPARTMENT—CITY OF BALTIMORE

049347

123

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Druid Hill ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Christy

(a) RESIDENCE. NO. 1002 Druid Hill ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oscar Christy

6 DATE OF BIRTH (month, day, and year): September 1894

7 AGE: Years 26 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Owner Leo Co

9 BIRTHPLACE (city or town) (State or country): Owner Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Margaret Hamilton

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Oscar Christy

(Address): 1002 Druid Hill Ave

15 Filed DEC 29 1920 ROBERT J. KRAFFT Registrar

Burial Permit Giv

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/26/1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 26, 1920, that I last saw h[illegible] alive on Dec. 25, 1920, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Renal Calculi about 2 Mos.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. H. Humphries M. D.

12/28/1920 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 12/29 1920

20 UNDERTAKER: Samuel J Kemsley

ADDRESS: [illegible] Baltimore St

ec.—6-9-19—H. P. Co.—1000 Blks.

049348 HEALTH DEPARTMENT—CITY OF BALTIMORE 049348

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Stiles St ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna F Roehmer

(a) RESIDENCE. No. 1017 Stiles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August H. Roehmer

6 DATE OF BIRTH (month, day, and year): Aug 4, 1861

7 AGE: Years 59 | Months 4 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Christian C. Noz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Sophia Scheidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: August H. Roehmer (Address): 1017 Stiles St

15 Filed DEC 29 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Dec 27, 1920, that I last saw her alive on Dec 26, 1920, and that death occurred, on the date stated above, at 2 45 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis L Kattelle M. D.

Dec 29 1920 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Dec 30 1920

20 UNDERTAKER: H. Vander & Son — ADDRESS: 1710 Fleet St

Spec.—8-24-14—M. & T.—2000 Bks.

D49349 HEALTH DEPARTMENT—CITY OF BALTIMORE D49349

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 833 S. Second ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Frisch

(Residence in Baltimore: No. 833 S. Second St.; ..... yrs., ... mos. 4 hrs. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 28, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 4 hrs. ds.

If LESS than 1 day, 4 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Frisch

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia, Pa

12-MAIDEN NAME OF MOTHER Lillian V. Phillips.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Frisch

(Address) 833 S. Second St.

15- DEC 29 1920 ROBERT J. KRAUTER
Filed ....., 191.... Burial Permit Clerk

Important

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1920, to Dec. 28 1920, that I saw her alive on Dec. 28 1920, and that death occurred, on the date stated above, at 11.9 a m.

The CAUSE OF DEATH* was as follows:

Asphyxia - Premature Birth
at 7 months gestation

..... (Duration) ..... yrs. ..... mos. 4 hrs. ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. J. Lochbaker M. D.

Dec. 28, 1920 (Address) 806 S. 3rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Dec. 29, 1920

20-UNDERTAKER H. Gander & Son

ADDRESS 1710 Fleet St

Dec.—6-9-19—H. P. Co.—1000 Bks.

049350 HEALTH DEPARTMENT—CITY OF BALTIMORE 049350

CERTIFICATE OF DEATH.

79

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 S. Clinton ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Rehmert

(a) RESIDENCE. No. 1202 S. Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Gottlieb D. Rehmert

6 DATE OF BIRTH (month, day, and year) Nov. 26-1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	1	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christ. Schaut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lottie Tieman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth G. Davis
(Address) 1202 S. Clinton St.

15 Filed DEC 29 1920 ROBERT J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Dec 26, 1920, that I last saw h~~er~~ alive on Dec 26, 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tuttle M. D.

12/27, 1920 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Dec 29 1920

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St

pec.—6-9-19—H. P. Co.—1000 Bks.

649351 HEALTH DEPARTMENT—CITY OF BALTIMORE 649351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 25 Southern Ave ST.: Gardenia 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Ely

(a) RESIDENCE. NO. 25 Southern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: David Ely

6 DATE OF BIRTH (month, day, and year): Oct. 29. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co. Maryland

PARENTS

10 NAME OF FATHER: Allen Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Wheat

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: David Ely
(Address) 25 Southern Ave

15 Filed DEC 29 1920, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 19 20, to Dec 28, 19 20

that I last saw her alive on Dec. 27 19 20

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary): Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William Frymire, M. D.

Dec 28 19 20 (Address) 1407 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 31, 1920

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS 1739 Eager

DEC 29 1920 BOARD OF HEALTH Bureau of Vital Statistics

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49352

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 W. Baltimore St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Barrett

(a) RESIDENCE. No. 1919 W. Baltimore St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Barrett.

6 DATE OF BIRTH (month, day, and year) Unknown 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 85				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Connor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Florence Coyne
(Address) 1919 W. Balto St

15 Filed DEC 29 1920 ROBERT L KRAUSE Registrar
Burial Permit Clerk

THIS IS NOT A BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1920, to Dec 27th, 1920, that I last saw her alive on Dec 27th, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis of right side of body

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Unknown 000

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At 1919 W. Balto St.

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 30 1920
20 UNDERTAKER J. W. M. Gentleman	ADDRESS 1624 W. Mt Royal Ave

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage
1 day

Spec.—8-24-14—M. & T.—2000 Bks.

049353 HEALTH DEPARTMENT—CITY OF BALTIMORE 2049353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 Haw ST.; 27 WARD) REGISTERED No. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabth Demon,

(Residence in Baltimore: No. 653 Haw. St St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White.	married

6-DATE OF BIRTH, Aug 27th (Month) (Day), 1856 (Year)

7-AGE,	If LESS than 1 day,
64 yrs. 4 mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Anton Mallendorf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Demon

(Address) 653 Haw St

15- ROBERT E KRAUTER

Filed DEC 29 1920 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1920, to Dec. 27. 1920, that I saw her alive on Dec. 27. 1920; and that death occurred, on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Thas Norton M. D.

12/28 1920 (Address) 888 N. Paulst

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park.	Dec 29, 1920

20-UNDERTAKER	ADDRESS
John F. Lilly	1300 W. Fayette St

No further history

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

WALTJEN

HEALTH DEPARTMENT—CITY OF BALTIMORE

49354

49354

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N. Stricker ST.: 16 WARD)

2-FULL NAME Lucy Waltjen

(a) RESIDENCE. No. 711 N. Stricker St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augustus F. Waltjen

6 DATE OF BIRTH (month, day, and year) Dec. 22" 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	66	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel S. Barton

11 BIRTHPLACE OF FATHER (city or town) St. Marys Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa V. Bond

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Md.

14 Informant Augusta Barton
(Address) 711 N. Stricker St.

15 Filed DEC 29 1920, 19 ROBERT F. KRAUTHS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27" 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to Dec 27, 1920, that I last saw her alive on Dec 26, 1920, and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 7 mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. M. Lundquist, M. D.

Dec 27 1920 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec. 29 1920
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49355 D49355 D49355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 East 29th St ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sophia Van Daniker

(a) RESIDENCE. No. 301 East 29th St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Van Daniker

6 DATE OF BIRTH (month, day, and year) July 23 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mrs. Charles H. Uffelt

(Address) 301 East 29th St

15 Filed DEC 29 1920 ROBERT I. [illegible] Registrar

Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from January 1st 1917, to Dec 29, 1920, that I last saw her alive on Dec 27, 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma (Rectal)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion Debility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Stanley Gosnell M. D.

12/29, 1920 (Address) 9900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 30
20 UNDERTAKER Joseph B Cook	ADDRESS 100 N Gay St

Dec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49356 D49356

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lacey

(a) RESIDENCE. NO. St Agnes Hospital ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	A	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver (23

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Do not know

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Do not know

12 MAIDEN NAME OF MOTHER " Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant St Agnes Hospital
(Address)

15 Filed 12-28 1920 ROBERT I. [illegible] Registrar
DEC 29 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1920, to Dec 28, 1920, that I last saw h... alive on Dec. 28, 1920, and that death occurred, on the date stated above, at ... a. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion.

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis with terminal acute dilatation (duration) (?) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No-

What test confirmed diagnosis? Thoracentesis + Clinical exam.

(Signed) Paul E. Brown M. D.

12-29 1920 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 30 1920
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 N North Ave

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49357

CERTIFICATE OF DEATH.

049357

REGISTERED NO. 1079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 E. Biddle ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Thoman

(a) RESIDENCE. NO. 1412 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) John H. Thoman

6 DATE OF BIRTH (month, day, and year) Aug. 27- 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER Marcus Breuning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Thoman
(Address) 1412 E. Biddle St.

15 Filed DEC 29 1920 ROBERT J. LAZARUS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec., 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1920, to Dec 27 1920.

that I last saw h alive on Dec 27 1920

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Lob. Endocarditis
Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Asthma
Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Lebbeus Beck M. D.

, 19 (Address) 1846 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer

DATE OF BURIAL: 12/31 1920

20 UNDERTAKER: C.F.Evans & Son- 118 W. Mt Royal Ave

ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Bks.

D49358 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D49358

CERTIFICATE OF DEATH. 150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1023 Hollins ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Whelan

(a) RESIDENCE. NO. 1023 Hollins ST., 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/22/20

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER William P. Whelan

11 BIRTHPLACE OF FATHER (city or town) Chicago
(State or country)

12 MAIDEN NAME OF MOTHER Anna Catherine Behm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia Co.

14 Informant Wm P. Whelan
(Address) 1023 Hollins St

15 Filed DEC 29 1920, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/22 20, 1920, to 12/29, 1920, that I last saw him alive on 12/27, 1920, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Natural Cause

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Wm. A. Brehm, M. D.

12/29, 1920 (Address) 1023 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Dec. 30, 1920

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Baltimore

Spec.—5-19-13—M. & T.—500 Bks.

049359 HEALTH DEPARTMENT—CITY OF BALTIMORE 049359

CERTIFICATE OF DEATH.

5-79

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 417 N. Central Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James T. Wilson

(Residence in Baltimore: No. 417 N. Central Ave St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ? (Month) ? (Day) 1875 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dr

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Robert Wilson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos J Wilson

(Address) 417 N. Central ave

DEC 29 1920

Filed ....., 191.....

ROBERT E. TRAUTEN
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day) 28, 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1918, to Dec 8 1920, that I saw him alive on Dec 8 1920, and that death occurred, on the date stated above, at 7.10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) A. E. Hornstein M. D.

12/28, 1920. (Address) 733 Augusta St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Dec 30th 1920

20-UNDERTAKER Chas H Bailey — ADDRESS, 1427 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49360 HEALTH DEPARTMENT—CITY OF BALTIMORE D49360

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 Mit St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ray

(a) RESIDENCE. No. 1332 Mit St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Ray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Timms

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Wm Ray
(Address) 1332 West Mt

15 Filed Dec 29 1920, 19 BURIAL PERMIT

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Dec 27, 1920, that I last saw him alive on Dec 28th, 1920, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Comatose — death occurring following day after birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Slight Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Robertson, M. D.

, 19 (Address) 717 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	12/29/20
20 UNDERTAKER	ADDRESS
H C Wedefeld	914 Grant Av.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0449361 HEALTH DEPARTMENT—CITY OF BALTIMORE 0449361

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Boone.

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records. (Address) City Hospital, Bay View.

15 Filed DEC 29 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1920.

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1915, to Dec. 26, 1920, that I last saw h[illegible] alive on Dec. 26, 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Asthenia - senilis.

(Cerebral Hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) J. H. Eyman, M. D.

Dec 29 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Dec 30 1920
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Monty-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49362 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49362

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1618 W. Mulberry St ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meta Evalyn Morgan

(a) RESIDENCE. NO. 1618 W. Mulberry St ST., WARD. Washington D. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 7/10/1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dubuque Iowa

PARENTS

10 NAME OF FATHER William W. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dubuque Ia.

12 MAIDEN NAME OF MOTHER Evalina Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant William W. Morgan.

(Address) 2012 N.W. 12th. S. Wash. D.C.

15 Filed Dec 29 1920 Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28/'20 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1920, to Dec. 28 1920, that I last saw her alive on Dec. 28th 1920, 19, and that death occurred, on the date stated above, at 3.00 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Dec 29 1920
20 UNDERTAKER Mrs Rosa Elliott	ADDRESS 1715 14th and U

Spec.—8-24-14—M. & T.—2000 Blks.

D.49363 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49363

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2221 Eutaw Place ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Rosenfeld

(Residence in Baltimore: No. 2221 Eutaw Place St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, April (Month) 24 (Day), 1861 (Year)

7-AGE, 59 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Bernard Stern

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rachael Meyers

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Myers

(Address) 2221 Eutaw Place

15- DEC 29 1920 ....., 191..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1919, to December 28 1920, that I saw her alive on December 28 1920, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

1. Cerebral Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 4 yrs. — mos. — ds.

(Signed) W B Dorsey M. D.

12/29, 1920. (Address) 113 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew

DATE OF BURIAL, Dec. 29, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Balto

pec.—6-9-19—H. P. Co.—1000 Bks.

D.49364 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49364

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 502-E-39 St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edwin Griffith

(a) RESIDENCE. No. 5026-39 St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1844

7 AGE: Years 76 Months 6 Days 8 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 034

(b) General nature of industry, business, or establishment in which employed (or employer): Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire Md

12 MAIDEN NAME OF MOTHER: Mary Faulkner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Md

14 Informant: Laura Griffith

(Address) 502-E-39

15 Filed Dec 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Dec 28, 1920, that I last saw h[illegible] alive on Dec 28, 1920, and that death occurred, on the date stated above, at 11. 9. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. E. Bunting, M. D.

19 (Address) 634 Gramercy Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 31 1920
20 UNDERTAKER	ADDRESS
H. Kuhlmann & Son	Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49365 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49365

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Union Memorial Hospital ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Diedrich

(a) RESIDENCE. No. 318 N. Robinson Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Albert Diedrich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Lillian Plumhoff.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mrs. Lillian Diedrich
(Address) 318 N. Robinson St.

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from August 31st, 1920, to Dec. 28, 1920, that I last saw her alive on December 28, 1920, and that death occurred, on the date stated above, at 11.55 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Dec 30 1920
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Blks.

D.49366 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49366

CERTIFICATE OF DEATH.

28

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 N. Port ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Marie Lamley

(Residence in Baltimore: No. 1816 N Port St. St.; 20 yrs., 10 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	S

6-DATE OF BIRTH, February (Month) 10 (Day) 1900 (Year)

7-AGE, 20 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Lamley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Lingan

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Lamley

(Address) 1816 N. Port St.

15- Filed ..... 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Dec 28 1920, that I saw h er alive on Dec 27 1920, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Extensive).

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J. Ard M. D.

Dec 28, 1920 (Address) 2005 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 30., 1920

20-UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,49367 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49367

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 605 N. Conk ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Wohlfiled

(a) RESIDENCE. NO. 605 N Creenglen ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 18. 1889

7 AGE: Years 31 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Store

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Chas. Wohlfiled

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Sonia Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas Wohlfiled

(Address): 605 N. Conkling St

15 Filed 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 19 20

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 19 20 to Dec 29 19 20

that I last saw h alive on Dec 29 19 20

and that death occurred, on the date stated above, at 3 Am

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of desth? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. J. Wyeth, M. D.

Dec 29 19 20 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 1/1/21 19

20 UNDERTAKER: Philip Herring

ADDRESS: 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49368 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49368

100

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1142 Scott ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Katherine Brimmer

(a) RESIDENCE. No. 1142 Scott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Freddie J. Brimmer

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	2	3	

8 OCCUPATION OF DECEASED 37

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Hazeremus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Freddie J. Brimmer

(Address) 803 Scott St.

15 Filed DEC 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Dec 27, 1920, that I last saw her alive on ....., 19..., and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley Strong M. D.

12/29 1920 (Address) 729 Herkimer Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 30 1920

20 UNDERTAKER Jm. Mc John M. Gensel

ADDRESS 801 W. Fayette St.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to ~~Tonsilitis~~
Tonsilitis

D.49369 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fountain Street ST.: 10 WARD) 184 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	single

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, about ..... yrs. ..... mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dr. Janney .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. W. Coldsmith

(Address).....

15- Filed ....., 191.....
Robert P. Harrison, Registrar.
DEC 29 1920 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 27 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... us .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

..... Strangulation (Homicide) .....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) none

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... J. S. Hennessy ..... M. D.
(Coroner.)
Dec. 27, 1920 (Address) 2807 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER	ADDRESS
Commissioner Health,	DEC 29 1920

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49370 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49370

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 219 W. Hamburg ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jackson

(a) RESIDENCE. NO. 219 W Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Premature

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/28/20

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) Premature

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Percy Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Marjorie Parker Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Margaret Jackson

(Address) 219 W Hamburg

15 Filed ..., 19 ... Registrar

DEC 29 1920 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/28, 1920, to 12/28, 1920, that I last saw h alive on 12/28, 1920, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5 mo. pregnancy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) maternal Syphilis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Brumbaugh, M. D.

12/29, 1920 (Address) 1 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS DEC 29 1920

Spec.—6-9-19—11. P. Co.—1000 Bks.

40.49371 HEALTH DEPARTMENT—CITY OF BALTIMORE 40.49371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSPITAL #56 REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. St.: (Ward) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHEAL D. GROODY

(a) RESIDENCE. No. US PUBLIC HEALTH SERVICE HOSPITAL #56 Ward. 35
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26 yrs.	---	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) --------

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant
(Address) US PHS HOPITAL #56 Ft. MCHENRY.

15 Dec 29 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1920, to Dec. 27, 1920, that I last saw him alive on Dec. 27, 1920, and that death occurred, on the date stated above, at 6p.m. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary
Active.

Unknown (duration) -- yrs. -- mos. --- ds.

CONTRIBUTORY (Secondary) Tuberculosis of Larynx

-- (duration) yrs. mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Thomas R. Payne M. D.

Dec 29 1920 (Address) USPHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shenandoah Pa	Dec 29 1920

20 UNDERTAKER A Leinson & Bro

ADDRESS 127 E Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D.49372 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49372

CERTIFICATE OF DEATH.

81 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 E North Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Sample

(Residence in Baltimore: No. 1212 E. North Ave St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (Write the word.) Widower

6-DATE OF BIRTH, March 31, 1844. (Month) (Day) (Year)

7-AGE, 76 yrs. 8 mos. 28 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: fisherman
(b) General nature of industry, business, or establishment in which employed (or employer): O.C.

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Sapperman

(Address) 1212 E North Ave

15-

Dec 29 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 23 1920, to Dec 28th 1920, that I saw h[illegible] alive on December 27, 1920, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows: DOV

Carcinoma Uterus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 7 mos. ds.

(Signed) C. E. Fahey M. D.

Dec 29, 1920 (Address) 1212 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dawn De Grace — DATE OF BURIAL, Dec 30th 1920

20-UNDERTAKER, Leo G. Cook — ADDRESS Northern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49373

D.49373 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Payson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Magdalen Weaner

(a) RESIDENCE. No. 410 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND OF~~ (or) WIFE of William Nicholas Weaner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Gettysburg, Pa.

PARENTS

10 NAME OF FATHER Andrew Stock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Neff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant June Stella Schwarzkopf
(Address) 410 N. Payson St.

15 Filed DEC 29 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1920, to Dec. 29, 1920, that I last saw her alive on Dec. 28, 1920, and that death occurred, on the date stated above, at 3:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) one yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Thrombo-phlebitis left femoral (duration) — yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Maurice E. Shamer, M. D.

12/29 1920 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gettysburg Pa	12/30/20
20 UNDERTAKER George A. Farley Sutton & Fayette	ADDRESS

TION IS VERY IMPORTANT

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.49374 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49374

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Fleet St ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E Leuschel

(a) RESIDENCE. No. 2400 Fleet St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Leuschel

6 DATE OF BIRTH (month, day, and year) Aug 2 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Gimmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Stauter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Leuschel (Address) 2400 Fleet St.

15 Filed DEC 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Dec 28 1920

that I last saw h.. alive on Dec 28 1920

and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with Asystolic & General Anasarca following acute Rheumatic Arthritis (duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Jaundice

(Signed) J. T. Runnels, M. D.

1229 1920 (Address) 800 N Bullitts Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Dec 31st 1920
20 UNDERTAKER Thos L. Miller	ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bka.

D.49375 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49375

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N Mountford ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Halste

(a) RESIDENCE. NO. 515 N Mountford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Halste

6 DATE OF BIRTH (month, day, and year) Feb 17-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Dr H B Jacobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Halste

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gerard L Halste (Address) 1997 N Patterson ave

15 Filed DEC 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 27, 1920, that I last saw him alive on Dec 26, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Dec 29, 1920 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Dec. 30. 1920.
20 UNDERTAKER Mrs. C. Miller.	ADDRESS 2334 Jefferson St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49376 D49376 +129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora M. Ridgway

(a) RESIDENCE. NO. Parsons W. Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry C Ridgway

6 DATE OF BIRTH (month, day, and year) Mar 7-1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Wm. H. Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Margaret Carvil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Record
(Address)

15 Filed DEC 30 1920 ROBERT E KRAUTER Registrar
Burial Permit Oleb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 —, 1920, to Dec 29 —, 1920 that I last saw h.. alive on Dec 29 —, 1920, and that death occurred, on the date stated above, at 3:12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism - following Hysterectomy for Myomata Uteri - OOBY

(duration) ..... yrs. ..... mos. 10 min.

CONTRIBUTORY (Secondary) none - except Surgical Operation (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 14, '20.

Was there an autopsy? no -

What test confirmed diagnosis? Clinical Observation

(Signed) L K Wharton, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parsons W. Va	12/30 1920
20 UNDERTAKER	ADDRESS
H E Hughes	424 N Broadway

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not malignant.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49377 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 W Lexington St.: 19 Ward) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lily Pelton

(a) RESIDENCE. No. 1617 W Lexington St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	42	un known		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant James C. Henson
(Address) 1617 W Lexington

15 Filed DEC 30 1920 19 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1920, to Dec 26, 1920, that I last saw h Ex alive on Dec 25, 1920, and that death occurred, on the date stated above, at 11.10 p m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (duration) yrs. 8½ mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McCard M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 30 1920
20 UNDERTAKER Daniel Fenton	ADDRESS 916 Penn

Spec.—8-24-14—M. & T.—2000 Bks.

049378 HEALTH DEPARTMENT—CITY OF BALTIMORE 049378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 N. Milton Ave. ST.; 8 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Perry

(Residence in Baltimore: No. 1031 N Milton Ave St.; 53 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Not Known, 1867.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
53 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Matthew Snyder

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Petrie Gordon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Elis. Joseph Perry

(Address) 1031 N. Milton Ave

15-

Filed DEC 30 1920, 191... ROBERT F KRAUTER Deputy Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-14-1920, to 12-28-1920, that I saw h[illegible] alive on 12-27-1920, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cardiac Valvular

Insufficiency

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pharyngitis Tonsilitis

(Duration) yrs. mos. 14 ds.

(Signed) J. Bunatee M. D.

12-29-, 1920 (Address) 1604 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Dec. 31, 1920
20-UNDERTAKER	ADDRESS
Henry Storck & Son	1301 E Eager St

pec.—6-9-19—H. P. Co.—1000 Bks.

1049379 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049379

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Diehl

(a) RESIDENCE. No. 1169 Ashland ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 16 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Diehl

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Clara Pullman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs. Peter Doerfler
(Address) 1409 Ashland Ave

15 Filed DEC 30 1920 ROBERT A KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1920, to Dec. 29, 1920, that I last saw him alive on Dec. 29, 1920, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Incipient Pulmonary Tb.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Pneumonic Plynes

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Tb bacilli in Sputum

(Signed) S W Kouwenhoven, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 31 1920
20 UNDERTAKER	ADDRESS
Henry Howell Lee	1801 E Eager

THIS IS VOID unless filled out in full

Spec.—6-9-19—H. P. Co.—1000 Bks.

049380 HEALTH DEPARTMENT—CITY OF BALTIMORE 049380

CERTIFICATE OF DEATH. 5 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3111 Windsor Av ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moritz Herman Helling

(a) RESIDENCE. NO. 3111 Windsor Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Louise Fuchs

6 DATE OF BIRTH (month, day, and year) Sept 22-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76 yrs	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 13

(b) General nature of industry, business, or establishment in which employed (or employer) Shops.

(c) Name of employer Union Railways

9 BIRTHPLACE (city or town) Dresden (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Helling

11 BIRTHPLACE OF FATHER (city or town) Dresden (State or country) Germany

12 MAIDEN NAME OF MOTHER Miller

13 BIRTHPLACE OF MOTHER (city or town) Dresden (State or country) Germany

14 Informant Anna Helling (Address) 3111 Windsor Av

15 DEC 30 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Dec 29, 1920, that I last saw him alive on Dec 28, 1920, and that death occurred, on the date stated above, at 7.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) hypostatic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 28-20

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Louis E. Reagen, M. D.

12/31, 1920 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Dec 31 1920
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North

TION is very important. Be sure

(C. affidavit over)

049381

HEALTH DEPARTMENT—CITY OF BALTIMORE

049381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST.; 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Bertha Baddock.

(Residence in Baltimore: No. 1216 E. Lexington St.; 25 yrs., mos. ds.)

Married

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Dec. 29, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levi

(Address) 1411 E Balto St

15- ROBERT J. KRAUTER

Filed DEC 30 1920 191... Registrar.

Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull Accd

(Duration) ....yrs.....mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs.....mos. 1 hr. ds.

(Signed) G. C. Wade M. D.

(Coroner.)

29 Dec., 191.. (Address) 1420 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Herring Co

DATE OF BURIAL, 12/30, 1920

20-UNDERTAKER Jack Levi

ADDRESS 1411 E Balto

City of Baltimore, State of Maryland to wit:

Be it known by this presents, that on this Third day of Janu
in the year Nineteen Hundred and Twenty one before me the subscriber a
Notary Public in and for the City and State aforesaid personnally app
Hyman Baddock of the City and State aforementioned and made oath in d
of law and saith that his wife Esther Bertha Baddock died on the 29th day of
in the year 1920 and that her correct age was Forty Three years, not
before 52 years.

Signed Hyman his + mark Baddock (Sea

Sworn to before me the subscriber a Notary Public this Third day of
January 1921.

Abraham A. Shochet

Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049382

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049382

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 153 N. Exeter St.: 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reba Siegel

(a) RESIDENCE. No. 153 N. Exeter St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home - duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 E. Baltimore St.

15 Filed DEC 30 1920 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1920, to Dec. 28, 1920, that I last saw h.r alive on Dec. 28, 1920, and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Greene, M. D.

12-30, 1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Dec. 30 1920
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49383 HEALTH DEPARTMENT—CITY OF BALTIMORE D49383

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ed Hospital ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harrison.

(a) RESIDENCE. NO. 938 E Biddle ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20-1909

7 AGE Years 12 Months Days If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) Balto
(State ~~or country~~) md

PARENTS

10 NAME OF FATHER Geo Harrison

11 BIRTHPLACE OF FATHER (city ~~or town~~) Balto md
(State ~~or country~~)

12 MAIDEN NAME OF MOTHER Fannie Kelly.

13 BIRTHPLACE OF MOTHER (city ~~or town~~) Balto
(State ~~or country~~) md

14 Informant Fannie Harrison
(Address) 938 E Biddle

15 Filed DEC 30 1920 ROBERT L BRUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Dec 29, 1920, that I last saw h[illegible] alive on Dec 29, 1920, and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Status Meningitis
Cerebral Lues Abrasions

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Acute Mastoiditis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical Findings

(Signed) J. J. Carroll, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 3 1921
20 UNDERTAKER Robt J Turner Jr	ADDRESS 1442 Park Ave

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

D49384 HEALTH DEPARTMENT—CITY OF BALTIMORE D49384

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 of W 25-th ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elvan McMcDonell

(Residence in Baltimore: No. 40 of W 25th St. St., 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 12, 1851
(Month) (Day) (Year)

7-AGE, 99 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, John Fanallen

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Ann Lemmon

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jerome McDonell

(Address) 404 W 25th St

15- DEC 30 1920 ROBERT TRAUTER Burial Permit Clerk

Filed DEC 30 1920, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1920, to Dec 28th 1920, that I saw h.. alive on Dec 28th 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
& Bladder

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jerome McDonell M. D.

Dec 28th, 1920. (Address) 404 W 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampstead | DATE OF BURIAL, Dec 31, 1920.

20-UNDERTAKER Wm Cook | ADDRESS 522 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49385 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D49385

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 McHenry ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Gillingham

(a) RESIDENCE. No. 750 McHenry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 22 ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H. Gillingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Lowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm H. Gillingham

(Address) 750 McHenry St.

15 Filed DEC 30 1920 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29- 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Dec 29, 1920, that I last saw h.. alive on Dec 29, 1920, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

1 Meningitis (Infantile)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Brun, M. D.

12/29, 1920 (Address) 127 Holland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Family Private Plot Clarke Station, A. A. Co.	Dec 30 20

20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard St.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple meningitis
due to gastro enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D49386

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N Calhoun ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hicks

(a) RESIDENCE. No. 1104 N Calhoun St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year) Nov. 27-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: Thomas Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles Co Md

12 MAIDEN NAME OF MOTHER: Elvie McQuay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co Md

14 Informant: Elvie Hicks

(Address): 1104 McCulloh

15 Filed DEC 30 1920 19 ROBERT F. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1920, to Dec 28, 1920, that I last saw h[illegible] alive on Dec 27, 1920, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows: Tabagate Bronchitis / Measles

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological examination

(Signed) Edw. V. Fitzgerald, M. D.

12/30 1920 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cemetery

DATE OF BURIAL: Dec 30 1920

20 UNDERTAKER: John H Owens

ADDRESS: 538 Dolphin St

THIS IS VERY IMPORTANT

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D49387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Queen Anns Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Moog.

(a) RESIDENCE. No. 12 Queen Anns Road WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susanna Rebecca Moog.

6 DATE OF BIRTH (month, day, and year) Sept 9. 1841

7 AGE	Years	Months	Days	If LESS than 1 day ✓ hrs. or ✓ min.
	79	3.	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer) Sea Captain
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bessie Moog (Daughter)
(Address) 12 Queen Anns Road

15 Filed DEC 30 1920 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Dec. 28, 1920, that I last saw him alive on Dec. 28, 1920, and that death occurred, on the date stated above, at 8.30p m.

The CAUSE OF DEATH* was as follows:

Endocarditis ✓
(duration) yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 4 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Chemical examination of urine

(Signed) Geo. C. Shannon, M. D.

, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Dec 31 1920
20 UNDERTAKER	ADDRESS
Henry H. Witzke	1531 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49388 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D49388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamilton S Hodgson.

(a) RESIDENCE. NO. 1229 E. Lanvale St. ST. Cecil WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 - 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55 ~~yrs~~	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Enameler.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Hamilton S Hodgson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Anne Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newyork State

14 Informant Hospital Records. (Address)

15 Filed ....., 19..... ROBERT E. LEACH Registrar

DEC 30 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Dec 29, 1920, that I last saw h.~~im~~ alive on Dec 29, 1920, and that death occurred, on the date stated above, at 7.35 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W R Mason, M. D.

29 XII, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Dec 31 1920
20 UNDERTAKER	ADDRESS
Robt J Turner Dec	1442 Bway

D49389

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D49389

1 PLACE OF DEATH

Registered No. C .....

City of Baltimore (No. 1603 E Chase St.: 7 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William L Schultz

(Residence in Baltimore: No. 1603 E Chase St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: Dec 29 (Month), 29 (Day), 1920 (Year)

7 AGE: ..... yrs. ..... mos. 2 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William L. Schultz

11 BIRTHPLACE OF FATHER (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie Wacker

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs William L. Schultz

(Address) 1603 E. Chase St

15 Filed DEC 30 1920 ROBERT P. LAMMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 29 (Month), 29 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Dec 29 1920, that I saw him alive on Dec 29, 1920, and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Lupus of Mastoid

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Insufficient Labor

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Chas F Taylor M. D.

Dec 30, 1920. (Address) 1225 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: Dec 30, 1920

20 UNDERTAKER: Henry Kreck & Son | ADDRESS: 1301 E Eager St

State CAUSE OF DEATH in plain terms, so that it can be understood by a layman. Omission of any item of information called for by this certificate is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D

D49390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49390

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Wallrode Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mina Kann

(a) RESIDENCE. No. 1919 Wallrode Av ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salmon Kann

6 DATE OF BIRTH (month, day, and year) June 27 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Oestriches

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Kann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant B Kann

(Address) 1919 Wallrode Ave

15 Filed DEC 30 1920 ROBERT A KRETZER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 A 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 19 20, to Dec 29, 19 20, that I last saw h alive on Dec 29, 19 20, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

~~1a~~ Pneumonia

Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia Sept Dec 36 hr

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Howard L Kahn, M. D.

Dec 29, 19 20 (Address) 207 W Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Dec 31 1920
20 UNDERTAKER	ADDRESS
Hart & Goodheim	1844 McKyld

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Streeper

D49391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49391

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 8 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Streeper

(a) RESIDENCE. NO. 1101 N. Washington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: [illegible]

6 DATE OF BIRTH (month, day, and year): Dec 26, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Chas. Streeper

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Amanda Ryon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Mrs. Orly J. Schumann

(Address) 837 N. Caroline St

15 Filed DEC 30 1920 19 ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30/20 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Dec 29, 1920, that I last saw h[illegible] alive on Dec 29, 1920, and that death occurred, on the date stated above, at 10:50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 2 days yrs. mos. ds.

18 Where was disease contrarted if not at plare of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Mountcastle, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	12/31/20
20 UNDERTAKER	ADDRESS
Zukin & Zukin	1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49392 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49392

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Collington Ave. WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza J. Yeager

(a) RESIDENCE. NO. 1401 N. Collington Ave. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced (or) WIFE of: Albert Yeager

6 DATE OF BIRTH (month, day, and year): Dec 5-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	-	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Abney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sophia James

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant: Albert Yeager

(Address) 1401 N. Collington

15 Filed DEC 30 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Dec 28, 1920, that I last saw h[illegible] alive on Dec 28, 1920 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Don't know duration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. E. Hagner, M. D.

Dec 29, 1920 (Address) 1301 N. Bat Rank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 12/30 1920

20 UNDERTAKER: Un. Corp

ADDRESS: 50 E N.

THIS IS very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49393 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49393

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Ann ST.; V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Rummel

(a) RESIDENCE. No. 504 S. Ann ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER George Rummel

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Dinsmore

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Elsie Rummel (Address) 504 S. Ann St

15 Filed DEC 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1920, to Dec 29, 1920, that I last saw h— alive on Dec 29, 1920, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Grippe Influenza

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Valentine, M. D.

Dec 29, 1920 (Address) 502 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick's Cemetery	Dec 31 1920
20 UNDERTAKER	ADDRESS
A. Sander & Son	1710 Flat St

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49394 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49394

CERTIFICATE OF DEATH. 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Eastern Ave ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schreiner

(a) RESIDENCE. No. 1608 Eastern Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Schreiner

6 DATE OF BIRTH (month, day, and year) Nov. 13 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Lillian Weber

(Address) 603 S. Washington St

15 Filed DEC 30 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 19 20

17 I HEREBY CERTIFY, That I attended deceased from Dec-5th, 1920, to Dec-29th, 1920, that I last saw her alive on Dec-29th, 1920, and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal carcinoma

(duration) — yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary) Old age

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William R. Johnson, M. D.

12/30 1920 Address) 2016 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cem	Jan 2 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	130 Read

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49395 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49395

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 W. Biddle St. St.: 11 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcella Regan,

(a) RESIDENCE. No. 244 W. Biddle St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas J. Regan,

6 DATE OF BIRTH (month, day, and year) June 8- 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Behan.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Regan
(Address) 244 W. Biddle St.

15 DEC 30 1920 19 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1920

17

I HEREBY CERTIFY, That I attended deceased from October 15, 1920, to Dec 29th, 1920,

that I last saw her alive on December 29th, 1920,

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) J. A. Blatard M. D.

Dec 29, 1920 (Address) 40 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery.	1/3/21. 19

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt Royal Ave

D.49396 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: St. Joseph's Hospital — REGISTERED No. C 175-001

CITY OF BALTIMORE (No. ... St.; 10 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Mary Agnes Burch

(Residence in Baltimore: No. 7180 Main St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F | 4-COLOR OR RACE: W. | 5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)

6-DATE OF BIRTH, ..., 1906 (Month) (Day) (Year)

7-AGE, 14 ....yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Victor E. Burch

11-BIRTHPLACE OF FATHER (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER, Mary Fahey

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- DEC 30 1920 Robert P. Harrison, Registrar.
....., 191.....
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 - 29, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Rupture of Liver

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Laceration

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Lamb Blake M. D. (Coroner.)

191... (Address) 1426 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Cathedral Cem	Dec. 31, 1920
20-UNDERTAKER	ADDRESS
F. A. Mauer & Son	108 Harford St

important. See instructions on back of certificate.

against doctor.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49397 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49397

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S. Fulton ave St. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bateman

(a) RESIDENCE. NO. 328 S. Fulton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel B. Bateman

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Thomas Leary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Samuel B Bateman

(Address) 328 S. Fulton ave

15 Filed DEC 30 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1919. to Dec. 28. 1920.

that I last saw her alive on Dec. 28. 1920.

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jas. Boyd Thompson, M. D.

12/29. 1920 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 31 1920
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	733 Hanover

THIS IS VERY IMPORTANT. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49398 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49398

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 35 S. Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Mack

(a) RESIDENCE. No. 35 S. Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1920

7 AGE	Years	Months	Days	If LESS than 1 day 15 hrs. or 15 min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Wash ful

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George H Mack

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sulbia Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant George H. Mack
(Address) 353 Carlton St.

15 Filed 19 Robert P. Harrison, Registrar

C 3 0 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 30 - 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/28, 19 20, to 12/30/20, 19.....,

that I last saw h alive on 12/29/20, 19.....,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J Finy, M. D.

12/30, 19 20 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Dec 31 1920

20 UNDERTAKER George J. Smith ADDRESS Coode & Fayette

TION IS very important. Be thorough.

Spec.—8-24-14—M. & T.—2000 Bks.

2049399 HEALTH DEPARTMENT—CITY OF BALTIMORE 2049399

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Hilton St. St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Murray

(Residence in Baltimore: No. 2105 Hilton St St.; 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 22, 1844 (Month) (Day) (Year)

7-AGE, 76 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Wm H Cathy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Johanna

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Winters

(Address) 2105 Hilton St

15-

DEC 30 1920 Robert P. Harrison, ..., 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 - 1920, to Dec. 28 - 1920, that I saw her alive on Dec. 28 - 1920, and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy & Left Hemiplegia

about 12 hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility & Exhaustion about one year

(Duration) yrs. mos. ds.

(Signed) Carlton McCook M. D.

Dec 30, 1920. (Address) 1007 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, Jan 3 1, 1921

20-UNDERTAKER H. C. Brauns & Son — ADDRESS 317 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Bks.

20.49400 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49400

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Crawford ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter A. Henderson

(Residence in Baltimore: No. 600 Crawford St.; 12 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1892
(Month) (Day) (Year)

7-AGE. 28 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (Odd Jobs)

9-BIRTHPLACE, (State or Country), Madison, N.C.

PARENTS.

10-NAME OF FATHER, Joshua Henderson

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Mc Kinnon

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nancy Henderson

(Address) 600 Crawford St—

15- Ready

Dec 30 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 20/12/1920, to 29/12/1920, that I saw h[illegible] alive on 29/12/1920, and that death occurred, on the date stated above, at 10.25 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

about 6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

about 3

(Duration) yrs. mos. ds.

(Signed) Ellwyn Field Boyle M. D.

29/12/1920 (Address) 4 N. Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Morton N C

DATE OF BURIAL, Dec 30 1920

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Fleet

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49401 ✓D.49401

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Riggs Ave St.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mary E. Nelson

(a) RESIDENCE. No. 1523 Riggs Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC 10th-20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Pinkney

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Dora Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Dora Nelson
(Address) 1523 Riggs Ave

15 Filed DEC 30 1920, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 30 1920

17 I HEREBY CERTIFY, That I attended deceased from DEC 10, 1920, to DEC 30, 1920, that I last saw her alive on DEC 29, 1920, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Luesveneal Infection Hepatitis (duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? "

What test confirmed diagnosis? Wassermann

(Signed) Morris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr. Auburn	DEC 31st 1920
20 UNDERTAKER	ADDRESS
Sam'l W. Crane Son	1400 Madison

DEC 30 1920

TION IS very important. See instructions on

Withers

D.49402 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 616 S Paca ST. W WARD) REGISTERED No. C 91

2-FULL NAME Boston E. Withers

(Residence in Baltimore: No. 616 S Paca - Life St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 5 (Day), 1920 (Year)

7-AGE, ...yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, Arthur Withers

11-BIRTHPLACE OF FATHER (State or Country), B. C,

12-MAIDEN NAME OF MOTHER Susie Howard

13-BIRTHPLACE OF MOTHER (State or Country), Balt Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Withers

(Address) 616 S Paca st

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) H K Gorsuch M. D. (Coroner.)

12-30, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of denth ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Dec 31 1920
20-UNDERTAKER	ADDRESS
W M Cook	5 E Mt

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49403 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49403

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Montford St.: 7 Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Canton Hospital

(a) RESIDENCE. No. 900 N Montford St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline Ford

6 DATE OF BIRTH (month, day, and year): Baltimore 1864

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Md Glass Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mc Kown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Pauline Ford (Address) 900 N. Montford

15 Filed ..., 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Dec 29 1920, that I last saw h live on Dec 28 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Fisher, M. D.

(Address) 507 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 31 19
20 UNDERTAKER	ADDRESS
Frank Enoch & Son	1916 Eastern Ave

FOR is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

D.49404 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49404

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 64

CITY OF BALTIMORE: (No. 1466 William St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Hagan

(Residence in Baltimore: No. 1466 Wildcare St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	White	Widower

6-DATE OF BIRTH, Unknown (Month) (Day), 1851. (Year)

7-AGE, 69 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Puddler
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Michad Hagan

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Hagan

(Address) 1466 Wildcare

15-

Filed DEC 30 1920, 19[illegible] Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 29 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/20 1920, to 12/29 1920, that I saw h is alive on 12/29 1920, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

Cerebral (Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. 10 mos. ds.

(Signed) L J Burlington M. D.

12/30, 1920 (Address) 1026 Forest

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
[illegible]	1920.
20-UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49405 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49405

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 N. Hamburg ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dupont

(a) RESIDENCE. No. 1443 N. Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charlie Dupont

11 BIRTHPLACE OF FATHER (city or town) Montgomery
(State or country) Alabama

12 MAIDEN NAME OF MOTHER Emma Woodland

13 BIRTHPLACE OF MOTHER (city or town) Columbia
(State or country) South Carolina

14 Informant Charlie Dupont (Father)
(Address) 1443 N. Hamburg St.

15 Filed DEC 30 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Dec 29, 1920, that I last saw him alive on Dec 29, 1920, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Intra Cranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intra Cranial pressure due to forceps delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Rees, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health	ADDRESS DEC 30 1920
Per. Wm. K. WOODALL.	

THIS IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK

Spec.—8-24-14—M. & T.—2000 Bks.

DORSEY

20,49406

HEALTH DEPARTMENT—CITY OF BALTIMORE

20,49406

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 566 Oxford ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Dorsey

(Residence in Baltimore: No. 566 Oxford St.; 35 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... (Month) — (Day) — (Year) 1866

7-AGE, ... 54 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private Family

9-BIRTHPLACE, (State or Country), Frederick Md.

PARENTS.

10-NAME OF FATHER, Chas Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary E. Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Lavicia Stewart

(Address)..... 564 Oxford St

15- DEC 30 1920 Robert P. Harrison, ..., 191.....

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 27th (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Dec 27th 1920, that I saw h[er] alive on Dec 27th 1920, and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

1. .....
2. .....
3. Acute Nephritis (Duration) ..... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

..... (Duration) ..... yrs. 1 mos. — ds.

(Signed) Edward Cullen M. D.

Dec 29, 1920 (Address) 1330 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn Cem	Dec 31, 1920
20-UNDERTAKER	**ADDRESS**
Daniel Eustes	916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D.49407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49407

CERTIFICATE OF DEATH.

137-091

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Moore

(Residence in Baltimore: No. #517 Paca St. St.; 15 yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 26, 1903 (Month) (Day) (Year)

7-AGE, 17 yrs. ... mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 031

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, James Moore

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margret Williams

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Moore

(Address) 517 Paca St.

15- Filed ..... 19..... 191.....

Robert P. Harrison, Registrar.

DEC 30 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 12 1920, to December 27 1920, that I saw her alive on December 27 1920, and that death occurred, on the date stated above, at 5 10 A. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) ... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

(Signed) W. Gee M. D.

Dec 27, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bushan's Middle Neck Cem. DATE OF BURIAL, Dec 31., 1920

20-UNDERTAKER Thos. Kelly ADDRESS 114 N. Schroeder St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49408 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49408

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen White

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 DEC 30 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 30, 1918, to December 27, 1920, that I last saw her alive on December 26, , 1920, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Syphilis; hemiplegia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann.

(Signed) B H Evman, M. D.

12/27/ 19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 31 1920
20 UNDERTAKER	ADDRESS 114 N.
Burns & Leonard	Schroeder

THIS IS VERY IMPORTANT. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49409 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49409

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Eastern Ave.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth. Balezaitis

(a) RESIDENCE. NO. 2211 Eastern ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow.

6 DATE OF BIRTH (month, day, and year) Unknown 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Leshert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Greshock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Kalwa (Address) 2211 Eastern

15 Filed DEC 30 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from October - 1, 1920, to Dec - 29 -, 1920, that I last saw h.. alive on Dec 29 -, 1920, and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Hosita -

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis? Tuberculin

(Signed) Signature illegible, M. D.

30/xx 19 20 (Address) 125 S Bond -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 3 1921
20 UNDERTAKER	ADDRESS
Wm F. Hallowski	168 East

Spec.—8-24-14—M. & T.—2000 Bks.

D.49410 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49410

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Thame ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Les Kows Ka

Residence in Baltimore: No. 1526 Thame St. Left yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, December 2, 1901
(Month) (Day) (Year)

7-AGE, 19 yrs. mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Can Factory
(b) General nature of industry, business, or establishment in which employed (or employer): Mrs Thom

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andrew Les Kows Ki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Ane Berdisz

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Les Kows Ki

(Address) 1526 Thame St.

15-

Filed....., 191.. Robert P. Harrison, Registrar.

DEC 30 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 11 1920, to December 28 1920, that I saw h[er] alive on December 28 1920, and that death occurred, on the date stated above, at 3.22 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncchitis

(Duration) 2 yrs. mos. ds.

(Signed) L. J. Semanchik M. D.

Dec 29 1920. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary — DATE OF BURIAL, Dec 31, 1920.

20-UNDERTAKER Mrs Frazier — ADDRESS 1116 East

D.49411

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.49411

CERTIFICATE OF DEATH

92

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 700 Harvey ST. 24 WARD)

2 FULL NAME Joseph C. Flanagan

(Residence in Baltimore: No. 700 Harvey St. St.: 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6 DATE OF BIRTH: June (Month) 28 (Day), 1898 (Year)

7 AGE: 22 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Thomas J. Flannigan

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Nellie C. Flanagan

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Hoerl

(Address) 767 Frederick Ave. Catonsville Md.

15. Robert P. Harrison

DEC 30 1920 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 30 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 2, 1920 to Dec 30 1920 that I saw him alive on Dec 30 2, 1920 and that death occurred, on the date stated above, at 4 05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Pulmonary edema

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. S. Sheppard M. D.

12-30-, 1920 (Address) 723 E Fayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Jan. 1, 1921

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49412 HEALTH DEPARTMENT—CITY OF BALTIMORE D49412

CERTIFICATE OF DEATH.

REGISTERED NO. 1479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Madison Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Benn

(a) RESIDENCE. NO. 2013 Madison Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Matilda Benn

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Benn
(Address) 1411 Eutaw St

15 DEC 31 1920 ROBERT B. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Dec. 29, 1920, that I last saw him alive on Dec. 29, 1920, and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis - oedema of lungs (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? / own

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leitz, M. D.

12/30, 1920 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Hebrew Cem	12/31 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049413 HEALTH DEPARTMENT—CITY OF BALTIMORE 049413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Somerset ST.; 5 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patience Rebecca Aquilla

(a) RESIDENCE. No. 506 Somerset ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Aquilla

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Otha Savoy

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Savoy

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Samuel Aquilla.
(Address) 506 Somerset St.

15 Filed DEC 31 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from December 27 19 20 to December 29 19 20

that I last saw h alive on December 29 19 20

and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with heart complication

Duration 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of Old Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirm diagnosis? clinical

(Signed) Wallace A. Mear M. D.

12 30 19 20 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan 2 1921
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	1531 N. Caroline

CAUTION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0449414

HEALTH DEPARTMENT—CITY OF BALTIMORE

0449414

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1708 Wilkens Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizbeth Bruce

(Residence in Baltimore: No. 1708 Wilkens Ave St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 16, 1855 (Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country), Cumberlaney England

PARENTS.

10-NAME OF FATHER, John Sanyer

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER ? Autumn

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. R. Bruce

(Address) 1708 Wilkens ave

15- Filed DEC 31 1920 191.....

ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1920, to Dec 28 1920, that I saw her alive on Dec 28 1920, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Lee A. Cook M. D.

12.30, 1920 (Address) 541 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem

DATE OF BURIAL, Dec. 31., 1920

20-UNDERTAKER Robert Brooks & Son

ADDRESS Baltimore Md

Important. See instructions on back of Burial Permit.

Spec.—6-9-19—H. P. Co.—1000 Bks.

d49415 — HEALTH DEPARTMENT—CITY OF BALTIMORE — d49415

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 W. Barre ST. 21 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard E. Spedden

(a) RESIDENCE. No. 818 W. Barre ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector 086

(b) General nature of industry, business, or establishment in which employed (or employer): Gas & Elect Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Spedden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Susie Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Annie Spedden

(Address): 818 N Barre st

15 Filed DEC 31 1920 ROBERT I. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1920, to Dec. 28, 1920, that I last saw h[illegible] alive on Dec 28, 1920, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) John D. Blake M. D.

12/31, 1920 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	12-31 1920
20 UNDERTAKER: Robert W. Burns & Son	ADDRESS Calhoun Hollins st

D49416 D49416 D49416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Equitable Bldg. St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George ~~Curry~~ Curry

(Residence in Baltimore: No. Dundalk. Balto Co Md St.; yrs., mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ~~July~~ 4 (Month) (Day), 1866 (Year)

7-AGE, 54 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Elevator Op
(b) General nature of industry, business, or establishment in which employed (or employer)... Operator

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Curry

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country) Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Maloney

(Address) 23 East Ship Road

15- Dundalk, Md

Filed DEC 31 1920 ROBERT B KRAUTER Registrar.

Burial Permit Given

CAUSE OF DEATH to be plainly written, and all questions answered as far as possible. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Neck broken — Caused by being Crushed by Elevator

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Chas Gilroy M. D.

(Coroner) 1657 Bway (Address)

Dec 28, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Jan 1, 1921

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond

Spec.—8-24-14—M. & T.—2000 Bks.

W49417

HEALTH DEPARTMENT—CITY OF BALTIMORE

W49417

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 South Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcelia Ringlet.

(Residence in Baltimore: No. 116 South Madeira St. St. 1 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb (Month) 14 (Day), 1857 (Year)

7-AGE, 63 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Epron

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Nancy Carback

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter T. Barber

(Address) 116 South Madeira St

15-

Filed DEC 31 1920 ROBERT B KRAUTER Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1920, to Dec 29 1920, that I saw her alive on Dec 29 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alfred A Brodrick M. D.

Dec 30, 1920 (Address) 818 Patterson Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem

DATE OF BURIAL, Jan 1, 1921

20-UNDERTAKER Frank A Finch

ADDRESS 915 N Gay St

Spec.—8-24-14—M. & T.—2000 Bks.

D49418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49418

CERTIFICATE OF DEATH.

REGISTERED NO. C 4137-20

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Bock

(Residence in Baltimore: No. Millersville, Md. St.: 42 yrs., mos. 1 ds.)

8 Days in City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec 27, 1878 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 0 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Edward Nichols

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ctelmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Max Bock

(Address) Millersville Md.

15- DEC 31 1920 ROBERT J. REAUTER Burial Permit Dutch

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Dec 28 1920, that I saw her alive on Dec 28. 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

following Mortical Delivery.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Eugene F. Hough M. D.

Dec 28, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery. DATE OF BURIAL, Dec. 31, 1920

20-UNDERTAKER George F. Ruth ADDRESS 1735 Harford Ave.

D49419 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D49419

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

PLACE OF DEATH

CITY OF BALTIMORE (No. 1207 Linden Ave St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

*FULL NAME Martha A. Shields

(Residence in Baltimore: No. 1207 Linden Ave St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, unknown (Month) (Day), 1855 (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thos. Shields

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Hubbard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew C. Snyder

(Address) 1207 Linden Ave

15- FILED DEC 31 1920 ROBERT B. KRAUTER Registrar Burial Permit Issued

CAUSE OF DEATH: In plain terms, so as to convey important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage 1 minute

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 30, 191... (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery DATE OF BURIAL, January 1, 1921

20-UNDERTAKER John Mitchell ADDRESS 1201 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D49420 HEALTH DEPARTMENT—CITY OF BALTIMORE D49420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Forest Road ST.; 27 WARD) REGISTERED NO. C 180

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Davis

(Residence in Baltimore: No. 514 Forest Road St.; 1yr. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 4, 1845 (Month) (Day) (Year)

7-AGE, 75 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert Davis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Caroline McConky

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella McDavis

(Address) 514 Forest Road

15-

Filed....., 191.....

ROBERT B KRAUTER Registrar.

DEC 31 1920 Burial Permit Clerk

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 1913, to Dec 29th 1920, that I saw h~~im~~ alive on Dec 29th 1920, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (? Senility)

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected Kidney, Prostate Enlarged

(Duration) ? yrs. mos. ds.

(Signed) Fordenham R. Clarke M. D.

Dec 29th, 1920. (Address) Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 31, 1920

20-UNDERTAKER John Ottotchell ADDRESS 1200 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1335 E. North Av. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginia Preston.

(a) RESIDENCE. No. 1335 E. North Av ST. 9 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wm. E. Preston.

6 DATE OF BIRTH (month, day, and year) 1862, 4, 27.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): for self.

(c) Name of employer: None.

9 BIRTHPLACE (city or town) (State or country): White Marsh Balto Co., Md.

PARENTS

10 NAME OF FATHER Joseph Russell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) White Marsh, Balto Co.

12 MAIDEN NAME OF MOTHER Mary Knotts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) White Marsh, Balto Co Md

14 Informant Mrs. Melba Baker (Address) 1335 E. North av.

15 Filed DEC 31 1920 19 ROBERT E LEAUTEY Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12, 29, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1920, to Dec. 28, 1920, that I last saw her alive on Dec. 28, 1920, and that death occurred, on the date stated above, at 11.05 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitis

Coma (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None,

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Jan. 1. 21

20 UNDERTAKER George J. Ruth ADDRESS 735 Harford ave

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049422

HEALTH DEPARTMENT—CITY OF BALTIMORE

049422

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134. N. Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delia. E. Martin

(Residence in Baltimore: No. 134. N. Carey St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Col	Single

6-DATE OF BIRTH, June 17, 1901
(Month) (Day) (Year)

7-AGE, 19 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Cambridge Md

PARENTS.

10-NAME OF FATHER, James. G. Martin

11-BIRTHPLACE OF FATHER (State or Country), D. C.

12-MAIDEN NAME OF MOTHER Rosetta Johnson

13-BIRTHPLACE OF MOTHER (State or Country), D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. James. G. Martin

(Address) 134. N. Carey St

15-

Filed DEC 31 1920 191 ROBERT H. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 20, to Dec. 29 1920, that I saw h[illegible] alive on Dec 22 1920, and that death occurred, on the date stated above, at 11:35 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 18 Yrs
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (Duration) yrs. 18 mos. 0 ds.

(Signed) Jno. H. Tomkins M. D.

Dec 30, 1920 (Address) 19 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Joan Cem	June 1, 1921
20-UNDERTAKER	ADDRESS
Samuel H. Essex Sr	1400 Madison

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D49423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49423

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2451 Barclay ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine P. Joyce

(Residence in Baltimore: No. 2451 Barclay St St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July (Month) 2 (Day), 1851 (Year)

7-AGE, 69 yrs. 5 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Saml. A. Price

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Parem

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allen Joyce

(Address) 102 N. 25th St. Balt 2nd

15- DEC 31 1920, 191 ROBERT P. LEAJEE Registrar.

Burial Permit 0101

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1920, to Dec 30 1920, that I saw her alive on Dec 30 1920, and that death occurred, on the date stated above, at 10.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - with remote

Complication

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeler M. D.

12.30, 1920. (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, 12.31, 1920

20-UNDERTAKER Henry W. Jenkins & Sons Co — ADDRESS Orchard & McCulloh

important. See instructions on back of certificate.

1049424 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049424

CERTIFICATE OF DEATH.

103

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3555 Great Air ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Jones

(Residence in Baltimore: No. 3555 Great Air St. (yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W.	Single

6-DATE OF BIRTH, Mar (Month) 17 (Day), 1842 (Year)

7-AGE, 78 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Laurel, Ind

PARENTS.

10-NAME OF FATHER Chas. B. Jones

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Martha Helen

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil L. W. Jones

(Address) 3555 Great Air St

15- ROBERT B. BREUER

Filed DEC 31 1920 191 Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Morrison M. D.
(Coroner.)

Dec 31 1920 (Address) 312 Belair

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Marys Hampden — DATE OF BURIAL, Dec 31, 1920

20-UNDERTAKER Horace Burgee & Son — ADDRESS 363 Halls Rd.

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-49425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 E. Lexington St.: 5 9th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Gibson

(a) RESIDENCE. No. 1123 E. Lexington St. 5. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Gibson

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt. 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 10 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md.

PARENTS

10 NAME OF FATHER Wm. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Rebecca Gibson (Address) 1122 E. Lexington St.

15 FILED DEC 31 1920 ROBERT E. LAZZELL Registrar

Burial Permit Given

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1920, to Dec 29, 1920, that I last saw h.. alive on ... 19 20, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) A. J. Nelson, M. D.

Dec 30 1920 (Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec. 31. 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D49426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49426

CERTIFICATE OF DEATH.

REGISTERED No. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Carlton St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Sugars

(Residence in Baltimore: No. 124 N. Carlton Ave St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 15, 1840 (Month) (Day) (Year)

7-AGE, 79 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Helper in Printing Plant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles Sugars

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Dorsey

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Sugars

(Address) 124 N. Carlton Ave

15-

Filed DEC 31 1920, 191... ROBERT N KRAUTER Registrar.
Burial Permit Clerk

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 25, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to Dec. 27 1920, that I saw h[illegible] alive on Dec 27 1920, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Heart Intermittent Pulsation 30 Minutes

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Double Inguinal Hernia

(Duration) 50 yrs. mos. ds.

(Signed) J. M. Hayes M. D.

....., 191... (Address) 1137 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, National Cem'y

DATE OF BURIAL, Dec 31., 1920

20-UNDERTAKER George H. Holland

ADDRESS 1631 Orleans Holland

049427 HEALTH DEPARTMENT—CITY OF BALTIMORE 049427

CERTIFICATE OF DEATH.

151

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2904 Hudson ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Chas Joseph Schnepp

(Residence in Baltimore: No. 2904 Hudson St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 09, 1912
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Schnepp

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Emma Bekendorf

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Schnepp

(Address) Baltimore Md

DEC 31 1920 Filed ..... 191... ROBERT B KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Fox Emsley M. D.
(Coroner.)
Dec 31 1920 (Address) 800 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Hill	1/3 1921
20-UNDERTAKER	ADDRESS
Kelly & Fales	230 N Howard

CAUSE OF DEATH to be plain, definite, and complete. Every item important. See instructions on back of certificate.

D49428 HEALTH DEPARTMENT—CITY OF BALTIMORE D49428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1423 Druid Hill St. 14 WARD) REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Brooks

(Residence in Baltimore: No. 1423 Druid Hill Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, Feb. 2, 1872
(Month) (Day) (Year)

7-AGE, 47 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elevator man
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, David Brooks

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Henderson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. Brooks

(Address) 1423 Druid Hill Ave

15- DEC 31 1920 ROBERT I KRAUTER
Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Dis.

(Duration) 3 yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Dec 29, 1920 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec. 31, 1920

20-UNDERTAKER Samuel Stanley ADDRESS W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1049429 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049429

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 First St. ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albina Gerczak.

(a) RESIDENCE. No. 2026 First ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Mar 27/20.

7 AGE: Years ..... Months 9 Days 3 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: dis

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos. Gerczak.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Maryland

12 MAIDEN NAME OF MOTHER: Martha Kmiecik.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md.

14 Informant (Address): Joseph Gerczak 2026 First St

15 Filed DEC 31 1920 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/30/20

17 I HEREBY CERTIFY, That I attended deceased from Dec 21 — 1920, to Dec 30 1920, that I last saw h[illegible] alive on Dec 30 — 1920, and that death occurred, on the date stated above, at 10 00 a.m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia — 9 ds

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? — Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) [illegible] M. D.

[illegible] (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 31 1920
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

D49430 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ 120 D49430

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 3605 Garrison Ave St.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Peter D. Della

(Residence in Baltimore: No. 3605 Garrison Ave St.: 85 yrs. 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: July (Month) 19 (Day), 1835 (Year)

7 AGE: 85 yrs. 5 mos. 10 ds. — If LESS than 1 day, ..hrs. or —min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 016
(b) General nature of industry, business, or establishment in which employed (or employer): Retired Builder

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (State or country): Not known

12 MAIDEN NAME OF MOTHER: Emma Morris

13 BIRTHPLACE OF MOTHER (State or country): Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora E Jones

(Address) 3605 Garrison Ave

15 DEC 31 1920 ROBERT J KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 29 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1920, to Dec 28 1920.
that I saw h im alive on Dec 28, 1920
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Many Months
(Duration) yrs. mos. ds

Contributory (SECONDARY) Endarteritis Prostate with Cystitis
(Duration) yrs. mos. ds.

(Signed), Henry Ns. Bartley M. D.
Dec 30, 1920 (Address) 2805 N. Ledbetter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: MOUNT OLIVET — DATE OF BURIAL: Jan 1 191[illegible]

20 UNDERTAKER: JOHN F. DENNY — ADDRESS: 715 LIGHT ST.

N. B.—Every item of information should be given. Exact statement of OCCUPATION may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be understood. Name of CITY or TOWN is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145283 2649431 — 1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 17 WARD) 7

REGISTERED NO. 2649431

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Holston

(a) RESIDENCE. NO. Jefferson City ST. Tennessee WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Ella Holston

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —— 80

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Henry Holston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Marie Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant (Address) J. H. Hospital Records

15 Filed DEC 31 1920 ROBERT I. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Dec 30, 1920, that I last saw him alive on Dec 30, 1920, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy (duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Carlisle S. Lenty, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jefferson City Tenn — DATE OF BURIAL Dec 31 1920

20 UNDERTAKER H. E. Hughes — ADDRESS 4th St. Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49432 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D49432

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 N Washington ST.: 8 WARD)

2-FULL NAME Mary Elizabeth Scales

(a) RESIDENCE. No. 1110 N Washington ST., 7th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1920

7 AGE: Years: August 30th | Months: 4 | Days: 3 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Birt Scales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kansas City Kansas

12 MAIDEN NAME OF MOTHER: Emma D Huber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Birt Scales
(Address): 1110 N Washington

15 Filed DEC 31 1920 ROBERT T KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 30th 11 am 1920, to Dec 11 2 Pm 1920, that I last saw her alive on December 30th 1920, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Catarrhal

Congestion of Brain (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Convulsions (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home place.

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Thomas J Turner, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Jan 1 19..

20 UNDERTAKER: E J Fanning & Son — ADDRESS: 1938 E Lafayette

TION is very important. See instructions on back of certificates.

2-20 649433 HEALTH DEPARTMENT—CITY OF BALTIMORE 649433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Found St. 15 Ward) 189 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(Residence in Baltimore: No. unknown (Found Alaska & Westwood Ave St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Dec. 28, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Police Dept.

(Address) Balto. Md.

15- Filed DEC 31 1920, 191.... ROBERT J. KRAUTER Registrar.
Burial Permit Oleyt

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....Jury.... (Inquest, autopsy or inquiry.) find that said deceased came to ....his.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....unknown.....

.....

.....

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Dec. 30 1920 (Address) 3802 E. Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, DEC 31 1920, 19....
20-UNDERTAKER	ADDRESS

HOPKINS HOSPITAL
Commissioner Health.
Per. Wm. E. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049434 HEALTH DEPARTMENT—CITY OF BALTIMORE 9-1-049434

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital S. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bittorf

(a) RESIDENCE. No. 1505 E. Pratt St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address) New City Hospital.

15 Filed DEC 31 1920 ROBERT P. KRAUTH Registrar

Medical Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 26 1920, to December 29 1920, that I last saw him alive on December 29, 1920, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peripheral gangrene of toes. (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) Bateman, M. D.

12/29/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	DEC 31 1920 19

20 UNDERTAKER Commissioner Health. ADDRESS

For Wm. E. WOODALL

TION is very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL

Stec.—6-9-19—H. P. Co.—1000 Bks.

D49435 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049435

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles McFarland

(a) RESIDENCE. No. 48 Market Place ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. McFarland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Carrie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed DEC 31 1920 ROBERT V. KRAUTER Registrar

Social Service Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1920, to Dec. 27, 1920, that I last saw him alive on Dec. 27, 1920, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. H. Fahnestock, M. D.

12-27-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 3 - 1920 19

20 UNDERTAKER	ADDRESS
Commissioner Health,	

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49436

CERTIFICATE OF DEATH.

REGISTERED NO. 20-09

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 905 Woodbourne Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Beckmann

(a) RESIDENCE. No. 905 Woodbourne Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret a. Beckmann.

6 DATE OF BIRTH (month, day, and year) Sept 28-1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Wm Beckmann.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret A. Beckmann
(Address) 905 Woodbourne Ave

15 Filed DEC 31 1920 ROBERT I. KRAUTER Registrar

Burial Permit Oleek

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29. 1920.

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 1920. to Dec 29 1920

that I last saw h[illegible] alive on Dec 29 1920

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
Edema

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia-
Bronchial (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 2042 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cemetery	Jan 1- 1921
20 UNDERTAKER William Cook.	ADDRESS 502 S. North Ave

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

Dr Pitts & off. Eutaw Place & Biddle St.

D.49437 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49437

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 818 W Mulberry St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J Murphy

(Residence in Baltimore: No. 818 W Mulberry St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Feb 22, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). do

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Michael Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann McGlone

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E A Smith

(Address) 3144 Cedar Ave

15- Filed DEC 31 1920, 191.... ROBERT B KRAUTER Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know of any

(Duration) yrs. mos. ds.

(Signed) H K Fornoff M. D.
(Coroner.)

12-31, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 1/1, 1921

20-UNDERTAKER William Cook

ADDRESS Sox & York Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 49438 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49438

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 E. Pleasant St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Richard Wormley

(Residence in Baltimore: No. 935 E. Pleasant St.; .....yrs. 5 mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Feb. (Month) 15 (Day), 1896 (Year)

7-AGE, 24 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O&W

9-BIRTHPLACE, (State or Country), Spotsylvania Co., Va.

PARENTS.

10-NAME OF FATHER, Ellis Wormley

11-BIRTHPLACE OF FATHER (State or Country), Carolina Co. Va.

12-MAIDEN NAME OF MOTHER, Mary Child

13-BIRTHPLACE OF MOTHER (State or Country), Caroline Co., Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wormley Nearest Kin

(Address) 935 E. Pleasant St.

15- Robert P. Harrison,
Filed ....., 191.....
Registrar.
Burial Permit Clerk.

DEC 31 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 30 (Day); 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920, to Dec. 29 1920, that I saw h[illegible] alive on Dec. 29 1920, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Shelton M. D.

Dec 31, 1920 (Address) 20 3 W. Hamburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Ct	Jan. 1st, 1921
20-UNDERTAKER	ADDRESS
L. H. Brown and Son	108 W. Mo

If not important. See instructions on back of certificate.

D49439 HEALTH DEPARTMENT—CITY OF BALTIMORE D49439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 175-005

CITY OF BALTIMORE (No. Maryland Gen. Hosp. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius J. Fishinger

(Residence in Baltimore: No. 3304 Pourhattan Ave St.; yrs. 39 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, Dec. 27, 1893 (Month) (Day) (Year)

7-AGE, 39 yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: (machinist) Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Julius C. Fishinger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Jane Sudart

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. McCully
(Address) 130 E. Fort Ave.

15- Robert F. Harrison, Burial Permit Clerk
Filed DEC 31 1920 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fracture of base of skull
Fall from wagon (Accident)
(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. D. Hennessy M. D. (Coroner.)
Dec. 30 1920 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place mar. In the hosp. of death yrs. mos. 9 ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death? E. North Ave. on the street
Former or usual residence 3307 Pourhattan Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Presbyterian Cem. Co.	1/1, 19
20-UNDERTAKER J. F. McCully	ADDRESS 130 E. Fort

N.B.—Every item of information should be carefully supplied. AGE must be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 49440

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49440

CERTIFICATE OF DEATH.

REGISTERED NO. C 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Riley

(Residence in Baltimore: No. #2611 Francis St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M.

6-DATE OF BIRTH, March 5, 1868. (Month) (Day) (Year)

7-AGE, 52 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. do.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co.

PARENTS.

10-NAME OF FATHER, Chas R. Favour.

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Emma Barlow

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Midland H. Riley

(Address) Box 216 Cumberland Md

15-

Filed Robert F. Harrison, Registrar.

DEC 31 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Decembr 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 30 1920; that I saw h[illegible] alive on Dec 30 1920; and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. G. Heyd M. D.

Dec 30, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Cem.

DATE OF BURIAL, Jan. 3rd, 1921.

20-UNDERTAKER W. W. Skinner

ADDRESS 1018 Edmondson Ave

Case of DEATH must be filled in at once. It is important. See instructions on back of certificate.

D.49441 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49441

CERTIFICATE OF DEATH.

4 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 418 W Lexington St.: WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Fischer

(Residence in Baltimore: No. 767 W. Lexington St. St.: yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Don't Know

6-DATE OF BIRTH. ....., 1.....
(Month) (Day) (Year)

7-AGE. 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), California

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Haust

(Address) 1305 Madison

15- Filed ....., 191.....
Robert P. Harrison,
Burial Permit Clerk and Registrar.

DEC 31 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy~~ or inquiry.) find that said deceased came to ~~his death~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Inhalation of Gas -
..... (Duration) ..... yrs. a few hrs. ..... ds.

CONTRIBUTORY (Secondary) Suicide
..... (Duration) ..... yrs. few hrs. ..... ds.

(Signed) H. R. Gorsuch M. D.
(Coroner.)

12-31, 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	January, 1921

20-UNDERTAKER	ADDRESS
Richard H. Curley	2016 Barclay St.

N.B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

20.49442 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49442

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Markley Ave ST.; 37 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~John~~ George Thomas Morris Sr

(Residence in Baltimore: No. 6 Markley Ave St.; ....yrs.,....mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. (Month) 25 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 5 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John T. Morris

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Nellie V. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Brown

(Address) McDonogh Md.

15-

Filed DEC 3 1920, 191.... Robert B. Harrison, Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to Dec 30 1920, that I saw h... alive on Dec 30 1920, and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Disease of Newly Born

(Duration)....yrs....mos. 24 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration)....yrs....mos....ds.

(Signed) Thos. A. Naylor M. D.

12/30, 192.. (Address) Pikesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Jan 1st, 1921.
20-UNDERTAKER Lilly Zeiler	ADDRESS 409 S. Wolfe St

CAUSE OF DEATH must be filled in plainly, and in ink or indelible pencil. Physician's certificate is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49443 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49443

CERTIFICATE OF DEATH. X 91-089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1650 Ashburton av ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Elms

(a) RESIDENCE. NO. 1650 Ashburton ST., WARD. Easton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Elms

6 DATE OF BIRTH (month, day, and year) March 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 046

(b) General natore of industry, business, or establishment in which employed (or employer) Paper Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant G B Blamm

(Address) 1650 Ashburton

15 Filed DEC 31 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Dec 30, 1920, that I last saw h[illegible] alive on Dec 30, 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam Symptoms

(Signed) Jas H Zirkle M. D.

19 (Address) 203 Paper Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md. DATE OF BURIAL: Jan 2 1921

20 UNDERTAKER: W Maurice Rountree ADDRESS 223 N Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49444 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49444

CERTIFICATE OF DEATH

X 29-09

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. White

(a) RESIDENCE. NO. Denaro Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 4. 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Stephen D. White

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Lee

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant F. L. Lewis
(Address) 925 Union Trust Co.

15 Filed 3/1 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 31 1920, that I last saw him alive on Dec 31 1920, and that death occurred, on the date stated above, at 9 50 A.m.

The CAUSE OF DEATH* was as follows:

Mastoidectomy, mitral insufficiency
Pneumonia. (6 days) work

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pericarditis —

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 23 '20.

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) T. H. Jamminsaug, M. D.

Dec 31 1920 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	Dec 31 1920
20 UNDERTAKER	ADDRESS Richmond
H. H. Jenkins & Sons Co	Va Norfolk St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 49445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49445

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Hillen ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. H. Woods

(Residence in Baltimore: No. 1032 Hillen St.; Abt 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Not Known (Month) (Day) 1861 (Year)

7-AGE, About 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John H. Woods

(Address) 2318 Barclay St

15- Filed Dec 31 1920, 191

Robert B. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 31, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 29 1920, to Dec 31 1920, that I saw h[illegible] alive on Dec 30 1920, and that death occurred, on the date stated above, at 4:25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Heart Disease

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) External cancer

(Duration) yrs. mos. ds.

(Signed) John D. Ellis M. D.

Dec 31 1920, (Address) 4365 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Jan. 3, 1921.
20-UNDERTAKER Henry Hosch & Son	ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49446 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49446

CERTIFICATE OF DEATH.

28 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Carlton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anderson

(Residence in Baltimore: No. 219 Carlton St.; 18 yrs., 9 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Col.	Single

6-DATE OF BIRTH, Mar 17, 1902 (Month) (Day) (Year)

7-AGE, 18 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. Anderson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Annie Cook

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Dickson

(Address) 219 N. Carlton st

15-

JAN 1 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to Dec 29 1920, that I saw her alive on Dec. 28 1920, and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1/2 ds.

(Signed) Wm. Bruce Tyner M. D.

Dec 31, 1920 (Address) 1706 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Jan 1st, 1921

20-UNDERTAKER A. Jones ADDRESS 207 S Shucker

28

CAUSE OF DEATH to be written in plain terms, so that it may be understood. All questions must be answered. Words "unknown" or "cannot be ascertained" will not be accepted when important. See instructions on back of certificate.

Earles

D. 49447 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2118 Mura St.; 8 WARD) 103

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Eash.

(Residence in Baltimore: No. 2118 Mura St.; yrs., Lift mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	

6-DATE OF BIRTH, May 31st (Month) (Day), 1919 (Year)

7-AGE, 1 yrs. 7 mos. ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John A. Earles.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eleanor Heck

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Earles

(Address) 2118 Mura St

15- Filed JAN 1 1921, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12/30 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Gastritis DWD

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. 2 mos. ... ds.

(Signed) ... M. D. (Coroner)

12/31/20 1921 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Jan. 1, 1921

20-UNDERTAKER Wm. C. Miller — ADDRESS 2334 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ate lot of peanuts bananas & other foods had convulsion & died

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49448 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49448

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2817 Taylor St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odelet Jardiz Sandler

(a) RESIDENCE. NO. 2817 Taylor St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21- 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Sandler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Retinia Fields

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Harry Sandler
(Address) 2817 Taylor st

15 Filed JAN-1 1921 By Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Dec 30, 1920, that I last saw h[er] alive on Dec 30, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) ....yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B. J. Herzog MD, M. D.

Dec 31, 1920 (Address) 1305 n Patterson Pk Av

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Jan 1st 1921

20 UNDERTAKER	ADDRESS
Geo. Webb & Son	2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Child had rickets.
Possibility of child's
heart condition being
congenital.

20.49449 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49449

CERTIFICATE OF DEATH.

Registered No. C 18 89

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6 St.: D. Amity St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Elizabeth Ruffner

(Residence in Baltimore: No. 6 D. Amity St St.; yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 10 (Day), 1920 (Year)

7-AGE, yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 608

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, Jas Ruffner

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Banks

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Franke

(Address) 6 D. Amity St

15- Filed JAN 1 1921, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, or~~ Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cold

(Duration) yrs. mos. 3 ds.

(Signed) W. R. Forsach M. D.
(Coroner.)

1/3/ 1921 (Address) 117 W. Davis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 1, 1921

20-UNDERTAKER Boring & Tedard — ADDRESS 1140 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49450 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49450

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Conchallo

(a) RESIDENCE. No. 850 S. Bond St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Conchallo

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed 12/31/20 Robert P. Harrison, Registrar

JAN 1 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from December 2, 1920, to December 30 1920, that I last saw him alive on December 30, 1920, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency.
Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolus.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test.

(Signed) Bitterman, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 1 1921
20 UNDERTAKER	ADDRESS
John F. Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

D.49451 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49451

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 709 Druid Hill Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Horace Bryant

(Residence in Baltimore: No. 709 Druid Hill Ave St.; yrs., 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, August 10, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Dufour

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Bryant

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Alberta Anthony

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Bryant

(Address) 709 Druid Hill Ave

15- Filed JAN 1 1921, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

..... (Duration) ..yrs. ..mos. 7 ds.

CONTRIBUTORY (Secondary) no history of any important

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 31, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Jan 2nd, 1921.

20-UNDERTAKER Harman & Wright ADDRESS 1364 Park Ave

N.B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49452 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49452

CERTIFICATE OF DEATH. A 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 N. Mount ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Bankins

(a) RESIDENCE. No. 1026 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) St Marys Co

PARENTS

10 NAME OF FATHER Clarence Bankins

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys

14 Informant Mrs Nolan (Address) 1026 N. Mount.

15 Filed JAN-1 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 19 20, to Jan 1, 19 21, that I last saw h. alive on Dec 31, 19 20, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Marys Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Sputum

(Signed) Regular Phy I. N. Wright, M. D.

Jan 1, 19 21 (Address) 209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Lawn St Marys Co	Jan 2d 1921
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1364 Carey St

mation should be carefully supplied. Age should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D.49453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49453

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Smithei

(a) RESIDENCE. No. 130 Ruter St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd Carter by

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ada Burd
(Address) 1804 Ruter St

15 Filed ..... 19 .....
JAN 3 1921
Robert F. Harrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-28-20. 19 ..... to 12-30, 1920, that I last saw him alive on 12-30, 1920, and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia.

6 hours.
(duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-28-20

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. H. Richardson, M. D.

. 19 (Address) Md. Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delaneburg Va	Jan 1st 1921
20 UNDERTAKER Geo H Holland	ADDRESS 163 Albemarle Ave

Mail 604

INSTRUCTIONS.—WRITE PLAINLY. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 49454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49454

CERTIFICATE OF DEATH.

91-078

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2068 Harris alley ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie M Cady

(Residence in Baltimore: No. 206 S Harris Alley St.; ....yrs. 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 30 (Day), 1914 (Year)

7-AGE, ...yrs. 6 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Cady

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Dankelis

(Address) 204 S Morris st

15-

Filed.....Robert D. Harrison.....
Registrar.

AUG - 1 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Dec 30 1920, that I saw h-d alive on Dec 30 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Broncopneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Norbert C. Hetrick M. D.

Dec 31, 1920 (Address) 2151 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL. Jan 2., 1921

20-UNDERTAKER John J Feldt — ADDRESS 1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. All questions must be answered if possible, as the information is important. See instructions on back of certificate.

Phy. could give no history of any other infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49455 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49455

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 S. Twelfth ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Brubaker

(a) RESIDENCE. No. 500 S. Twelfth ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Brubaker.

6 DATE OF BIRTH (month, day, and year) Jan 5- 1862 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	~~58~~	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER David Brubaker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Elizabeth Brubaker 500 S. Twelfth St.

15 Filed JAN 1 1921 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1920

17

I HEREBY CERTIFY, That I attended deceased from December 9th, 1920, to December 30, 1920, that I last saw h~~e~~ alive on December 30, 1920, and that death occurred, on the date stated above, at 9. 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) ✓ —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No ✓

What test confirmed diagnosis? ✓

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Paxtang Cem. Harrisburg Pa.	Jan. 3 1920
20 UNDERTAKER	ADDRESS
Lilly & Zink	403 S. Front St

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.49456 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49456

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Cedar ave ST. Westport 25 WARD)

2-FULL NAME Charles a Bloom

(a) RESIDENCE. No. 307 Cedar ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed, or Divorced~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 18th 1920

7 AGE — Years: — Months: 9 — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas a Bloom Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltio

12 MAIDEN NAME OF MOTHER Lillie McCall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltio

14 Informant Chas a Bloom Jr
(Address) 307 Cedar ave

15 Filed JAN-1 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1920

17 I HEREBY CERTIFY, That I attended deceased from 12/30, 1920, to 12/31, 1920, that I last saw h— alive on 12/31, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

History 3wks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) History 5 days ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard J Ferry, M. D.

12/31, 1920 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Jan 3 1921

20 UNDERTAKER: Robert Brotherson — ADDRESS CALHOUN Hollins

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49457 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49457

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Agnes Lanegan

(a) RESIDENCE. NO. St. Vincent's Asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Sister Lord
(Address): 1401 Division St

15 Registered: JAN-1 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1920, to Dec. 30, 1920, that I last saw her alive on Dec. 30, 1920, and that death occurred, on the date stated above, at 8:10 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Vincents Asylum.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Paul E. Brown, M. D.

12-31, 1920 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan 1st 1921
20 UNDERTAKER	ADDRESS
Martin Faherty & Sons	1827 W Pratt St

mation should be carefully supplied. Fact statement of DEATH
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

D.49458 HEALTH DEPARTMENT--CITY OF BALTIMORE D.49458

CERTIFICATE OF DEATH

91

REGISTERED NO. C.....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 4 Bond St.; WARD) 8

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary C. Henry

(Residence in Baltimore: No. 1513 N Bond St.; yrs. mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	Single

6 DATE OF BIRTH Dec 28, 1920 (Month) (Day) (Year)

7 AGE .....yrs. .....mos. 4 ds. | If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Balto City

PARENTS

10 NAME OF FATHER albert Henry

11 BIRTHPLACE OF FATHER (State or country) Balto city

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (State or country) Balto city

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) albert Henry

(Address) 1513 N Bond St

15 Filed JAN-1 1921, 191.... Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1920, to Jan 1 1921, that I saw h.. alive on Dec 31, 1920 and that death occurred, on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) .....yrs. .....mos. 3/4 ds

Contributory (SECONDARY) Oedema of lungs

(Duration) .....yrs. .....mos. 1/2 ds.

(Signed) James M Benton M. D.

Jan 1, 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 1, 1921.
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	619 Guilford ave

D.49459 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49459

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST.: 8 WARD)
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicolas A Lemos

(Residence in Baltimore: No. 1804 E. Monument St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, (Month) Feby (Day) 23, (Year) 1879

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 650

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Cornelius N Lemos

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Rose Davis

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clementine E Lemos

(Address) 1804 E Monument

15- Robert B. Harrison, Registrar.

JAN 1 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec (Day) 31, (Year) 1919

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull accident 6hr

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) H C Wade M. D.
(Coroner.)

1/3/1920, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, January 12 1920

20-UNDERTAKER Geo Colp & Sons — ADDRESS 1424 Bway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lbs.

D.49460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49460

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 W Mulberry ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Keelie Smith

(Residence in Baltimore: No. 1809 W Mulberry St.) (Or how long in Baltimore.....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 25 (Month) (Day), 1869 (Year)

7-AGE, 51 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] 166

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Smith

13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bruce E Mayer

(Address) 1809 W Mulberry

15- JAN 1 1921 Robert P. Harrison, 191..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1920, to Dec 30 1920, that I saw h[illegible] alive on Dec 30 1920, and that death occurred, on the date stated above, at 10-30 p.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. 2 mos. ds.

Signed Guy Mueller M. D.

12/31/20 191... (Address) 400 N Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westen Cemetery — DATE OF BURIAL, Jany 3, 1921

20-UNDERTAKER [illegible] — ADDRESS 144 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone insufficient and useless. Be particular and state fully all the facts which are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 49461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49461

CERTIFICATE OF DEATH.

REGISTERED NO. C 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Agnes Foster

(Residence in Baltimore: No. 2314 Mordecai Ave. St.; 58 yrs., 7 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 19 (Month), (Day), 1862 (Year)

7-AGE, 58 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. Henry P. Carroll

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Stonebraker

13-BIRTHPLACE OF MOTHER (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. P. Foster

(Address) 2314 Mordecai Ave.

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

JAN-4 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1920, to Dec 30 1920, that I saw her alive on Dec 30 1920, and that death occurred, on the date stated above, at 3 15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Brain with intra cranial Pressure

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) 3 yrs. ....mos. ....ds.

(Signed) E E Duncan M. D.

Dec. 30., 1920. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Jan. 3, 1921.

20-UNDERTAKER Wm. J. Rahmeyer Sons ADDRESS North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Leave nothing important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49462 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49462

CERTIFICATE OF DEATH. × 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thurman Allen Paris

(a) RESIDENCE. NO. Rising Sun Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Aug-31-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	4	×	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington (State or country) Delaware

PARENTS

10 NAME OF FATHER Charles A. Paris

11 BIRTHPLACE OF FATHER (city or town) Phila (State or country) Penna.

12 MAIDEN NAME OF MOTHER Helen Spahr

13 BIRTHPLACE OF MOTHER (city or town) Uniontown (State or country) Pennsylvania

14 Informant ~~Father~~ James. Corbyn (Address) Rising Sun Md

15 Filed JAN-1 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-29, 1920, to 12-31, 1920, that I last saw him alive on 12-31, 1920, and that death occurred, on the date stated above, at 12.35 A.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gen'l Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-29-20

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Manifestations

(Signed) W. F. Richardson, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del	Jan 1 1921
20 UNDERTAKER for Jobsdens Son	ADDRESS 2178 Pac

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49463 HEALTH DEPARTMENT—CITY OF BALTIMORE D49463

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 E. Eager ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Collins

(a) RESIDENCE. No. 1836 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced (write the word) —

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3 ?	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER James O'Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Cordia Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co, md

14 Informant Cordia Collins (Address) 1536 E. Eager St

15 JAN 2 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31- 1920

17

I HEREBY CERTIFY, That I attended deceased from 12-27- 1920, to 12-31- 1920, that I last saw h~~e~~ alive on 12-30- 1920, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

poor

about 11 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? her home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. T. Sangill M. D.

12-31 1920 (Address) 6 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbury Conn,	Jan 2nd 1921

20 UNDERTAKER Henry A. Doherty ADDRESS 1725 Harlem

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior to pneumonia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49464 HEALTH DEPARTMENT—CITY OF BALTIMORE D49464

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Jones

(a) RESIDENCE. No. 1832½ Mathews St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Roger Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emil Hemms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record J. H. H.
(Address)

15 FILED JAN 2 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 31 - 1920, to Dec 31 - 1920, that I last saw h[illegible] alive on Dec 31 - 1920, and that death occurred, on the date stated above, at 5-45 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Verne R Mason, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Vernon [illegible]	1-4 1921

20 UNDERTAKER ADDRESS

Chas. H. Johnson N. Carolina

9-16

mation should be carefully answered. Any [illegible] it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

049465

HEALTH DEPARTMENT—CITY OF BALTIMORE

049465

CERTIFICATE OF DEATH.

81 REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1013 Deatwood (or Sept) ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas F. Hopper

(Residence in Baltimore: No. 1304 Deatwood St.; yrs., mos., ds.)

Homewood Apts

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Dept. Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Ind 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Hopper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Kernan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Hopper

(Address) 1304 Deatwood

15- JAN 2-1921 ROBERT B KRAUTER

Filed ....., 191..... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Thursday .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: over

..... Cerebro Sclerosis .....

.....

.....

..... (Duration) ..... yrs. D mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Carcinoma Duodenum

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan ....., 1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Jan. 4, 1921

20-UNDERTAKER Henry Hoen & Son

ADDRESS 1301 E Eager St

W 1429

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

D49466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49466

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1229 E. Chase ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Bereis

(Residence in Baltimore: No. 1229 E Chase St.; 59 yrs. — mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. 5th, 1861
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
59 yrs. — mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER, George Bereis

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rosa Bereis

(Address) 1229 E Chase St

15- JAN 2 - 1921 Filed....., 191.... ROBERT E. KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1st, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22d 1920, to Jany 15th 1921, that I saw h[illegible] alive on Dec 30th 1920, and that death occurred, on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(Duration) ....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) ....yrs.....mos.....ds.

(Signed) Geo E Jones M. D.

Jany 1, 1921 (Address) 150 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemy	Jan 4, 1921
20-UNDERTAKER	ADDRESS
Henry Hoerth Son	1301 E Eager St

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049467

HEALTH DEPARTMENT—CITY OF BALTIMORE

049467

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 N. Gilmor ST.: 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily A. Gillis

(a) RESIDENCE. No. 1634 N. Gilmor ST., 15th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Carrol County Md

PARENTS

10 NAME OF FATHER John Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Appleby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Georgie Barger
(Address) 1634 N. Gilmor St

15 Filed JAN 2-1921 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Dec. 31, 1920, that I last saw her alive on Dec 30, 1920, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast & Intestines & general complications

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Weakness & Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visible symptoms

(Signed) Wm Grant, M. D

. 19 (Address) 2131 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 3 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049468 HEALTH DEPARTMENT—CITY OF BALTIMORE 049468

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. 1514 Division ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Clayland

(a) RESIDENCE. No. 1003 W. Fayette ST., WARD. Baltimore Md

(Usual place of abode)

Length of residence in city or town where death occurred all his life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Business Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Dr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William S. Clayland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Prudence Story

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs George Green

(Address) 1005 W. Fayette St

15 JAN 2-1921 ROBERT E. LEE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1920, to Jan 1 1921, that I last saw h... alive on Jan 1 1921, and that death occurred, on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of tibia (L)

(duration) 3 yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Metastatic sarcoma of lung (Rt)

(duration) yrs. 1 ? mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Oct 15-1917

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Microscopic.

(Signed) H. H. Sunnenburg M. D.

Jan 1 1920 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 7 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette

CAUSE OF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

049469 HEALTH DEPARTMENT---CITY OF BALTIMORE 8-049469

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 802 Beaumont Ave ST.; Grams 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia A. Lee.

(Residence in Baltimore: No. 862 Beaumont Ave St.; Grams 3 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Colored	Widow

6-DATE OF BIRTH: August (Month) 14 (Day) 1843 (Year)

7-AGE: 77 yrs. 4 mos. 16 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or country): Md. Unknown

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): Md. Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Rose Lee

(Address) 802 Beaumont Ave Grams

15 JAN 2 - 1921 — ROBERT P. BEAUTEL

Filed ....., 191 — Burial Permit Clerk — REGISTRAR

N. B.—Every item of information should be carefully supplied. All blanks should be filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly classified.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 31st (Month) (Day), 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920, to, December 31, 1920, that I saw h.. alive on December 31 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

cond

(Duration) 1 yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. 0 mos. ..... ds.

(Signed), Daniel J. Kt. Thos. Jenifer M. D.

Dec 31, 1920. [Address] Towson. Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Prospect Hill — DATE OF BURIAL: Jan 3rd 1921

20-UNDERTAKER: John Burns Sons — ADDRESS: Towson

Spec.—8-24-14—M. & T.—2900 Bks.

Hockstein

049470

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 049470

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Harmonson ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Hochstein

(Residence in Baltimore: No. 202 Harmonson St.; ....yrs. Life mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ...May.... (Month) ....4.... (Day), 1894 (Year)

7-AGE, ...26.... yrs. ....4.... mos. ....26.... ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Hochstein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henrietta Groer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Hochstein

(Address) 202 Harmonson St.

15- ROBERT I KRAUTER

Filed JAN 2 - 1931 191.. Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1930, to Dec 30 1930, that I saw h[illegible] alive on Dec 30 1930, and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ....yrs. 2 mos. 3 ds.

(Signed) Robert V Burch M. D.

Dec 31, 1930. (Address) 215 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, Jan 3rd 1931

20-UNDERTAKER C. W. Dill | ADDRESS 309 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L049471 HEALTH DEPARTMENT—CITY OF BALTIMORE L049471

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH Southern Hospital ST. 12 WARD) 120

CITY OF BALTIMORE (No.

2-FULL NAME Carrol R Hedrick

(Residence in Baltimore: No. 533 W 27th St.(yrs. 9 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec (Month) 12 (Day), 1895 (Year)

7-AGE, 35 yrs. mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Railroad
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Andrew J Hedrick

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Sarah Jacobs

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Hedrick

(Address) 533 W 27th St

15- JAN 2 - 1921 Filed, 191. ROBERT E KRAUTZ Registrar. Burial Permit Dept

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Kennedy M. D. (Coroner.)

Jan 2 1921 (Address) 253 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Freedom Pa

DATE OF BURIAL, Jan 2, 1921

20-UNDERTAKER E Le Roy Stifflet

ADDRESS 125 E Hoffman St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049472

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049472

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N. Caroline ST.: 10 WARD)

2-FULL NAME Louisa Bredehoeft.

(a) RESIDENCE. No. 914 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Gustav Bredehoeft.

6 DATE OF BIRTH (month, day, and year) Feb. 26th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82.	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER J. Rumpf.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis C. Bredehoeft.
(Address) 914 N. Caroline St.

15 Filed JAN 2 - 1921 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Jan 1, 1921, that I last saw h alive on Dec 31, 1920, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? none

(Signed) Orrie C. Clemens M. D.
Jan 4, 1921 (Address) 1419 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 3rd 1921
20 UNDERTAKER	ADDRESS
Mr & Mrs John H. Teufel.	801 W. Fayette St

mation should be carefully supplied. Any blanks should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49473 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49473

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 Independant ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Probst

(a) RESIDENCE. NO. 3013 Independant ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Probst

6 DATE OF BIRTH (month, day, and year) feb 4 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Engelhart Probst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Selchinow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E Probst
(Address) 1814 Broadway

15 Filed DEC 2 1921 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31 1920

17 I HEREBY CERTIFY, That I attended deceased from 12-19 1920 to 12-31 1920, that I last saw h[illegible] alive on 12-31 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

(Chronic Interstitial Nephritis 8
Uremia 8 days

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) H A Probst, M. D.

1-1 1921 (Address) 702 S Smith Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	June 3 1921

20 UNDERTAKER Woodcock & Son E Monument

ADDRESS

Information should be carefully supplied. Avoid use of UNKNOWN. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49474 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49474

150

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Myrtle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eddy Davis

(Residence in Baltimore: No. 919 Myrtle Ave St.; .....yrs.,.....mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngl

6-DATE OF BIRTH, Dec 29, 1920 (Month) (Day) (Year)

7-AGE, ...yrs.....mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jefferson Davis

11-BIRTHPLACE OF FATHER (State or Country), S.C.

12-MAIDEN NAME OF MOTHER Daisy McCoy

13-BIRTHPLACE OF MOTHER (State or Country), N.C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jefferson Davis

(Address) 919 Myrtle Ave

15-

Filed ..... 192.. ROBERT F. KRAUTER Registrar.

Burial Permit Clerk

JAN 2 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 1 1921, that I saw h.. alive on Jan 1 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Salivary Forament Ovale

(Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. Smathers M. D.

1-1....., 1921 (Address) 734 Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Dr Auburn

DATE OF BURIAL, Jan 2, 1921

20-UNDERTAKER Edward Eaton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.49475 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49475

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 751 Dover - St.: W Ward) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edud Dorsey

(Residence in Baltimore: No. 751 Dover - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colod	Sngle

6-DATE OF BIRTH, ... Oct (Month) 10 (Day), 1820 (Year)

7-AGE, ... 97 yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Wom' 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Howard Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Balto city

12-MAIDEN NAME OF MOTHER Ann Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ann Dorsey

(Address) 751 Dover

15- Filed JAN 3 1921, 191.... ROBERT P KRAUTER Registrar.

Burial Permit Given

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. The DISEASE causing DEATH must be stated. Words like CANCER, CONSUMPTION, PARALYSIS, DROPSY, CONVULSIONS, FEVER, etc., without explanation, CANNOT be accepted as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Capillary Bronchitis .....

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ..... Cold .....

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) ..... M. D. (Coroner.)

1-2, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Jan 3, 1921
20-UNDERTAKER Edud Easton	ADDRESS 916 Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D.49476 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 17 WARD) REGISTERED NO. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Johnson

(Residence in Baltimore: No. Union St — St.) (Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, (MARRIED) WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1869 (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown Gaines

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 826 N. Bond

15-

Filed JAN 2 - 1921 191 [redacted] B KRAUTER Registrar.

Burial Permit Oi

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12/30 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/28 1920, to 12/30 1920, that I saw h- alive on 12/30 1920, and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Septic Embolism due to Cirrhosis -

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) 4 yrs. mos. 6 ds.

(Signed) Wm. S. Thom M. D.

12/30, 1920 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Jan. 2, 1920

20-UNDERTAKER Samuel Hemsley ADDRESS 318 N. Bond St.

Mt. V. 2578

N.B.—Every item must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Remarks

Dr Stein states case was not luetic.
No further history.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D.49477 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49477

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 Green Willow ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Clinton

Residence in Baltimore: No. 524 Green Willow

St.; yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	Sing'l

6-DATE OF BIRTH, Nov. 6, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Clinton

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Mary A. Medley

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Clinton

(Address) 524 Green Willow

15- ROBERT B KRAUTER

Filed ....., 191.... Registrar.

JAN 2-1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Entero-Colitis

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

Dec 31, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Jan 2, 1920

20-UNDERTAKER Samuel Housley ADDRESS 378 N Bidd

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49478

97

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Laught

(a) RESIDENCE. NO. 124 E. Randall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Laucht.

6 DATE OF BIRTH (month, day, and year) Dec 27-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Smart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. John H Laucht. (Address) 124 E Randall

15 Filed JAN 2-1921 ROBERT P. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Dec 31, 1920 that I last saw her alive on Dec 31, 1920 and that death occurred, on the date stated above, at 8.05 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
Rt Lung

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Withdrawal of pus

(Signed) W. L. Roy Lumpkin M. D.

, 19 (Address) Maryland Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	1/3 1920
20 UNDERTAKER	ADDRESS
J. F. McCully	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D49479 HEALTH DEPARTMENT—CITY OF BALTIMORE D49479

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital ST.) 1 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Weinel

(Residence in Baltimore: No. 502 S. Ellwood St.) Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Single

6-DATE OF BIRTH. Aug 1, 1878
(Month) (Day) (Year)

7-AGE. 42 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Piledriver
(b) General nature of industry, business, or establishment in which employed (or employer). Stanford & Brooke

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm. Weinel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katharine Miller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine Weinel

(Address) 502 S. Ellwood

15- Filed JAN 2 - 1921, 191.... ROBERT B KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
Accident
(Duration) yrs. mos. 1/6 ds.

CONTRIBUTORY (Secondary)* Shock
(Duration) yrs. mos. 1/2 ds.

(Signed) H. Gilde M. D.
(Coroner.)

12/31/20 191.. (Address) 43 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Jan 3, 1921

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

49480

HEALTH DEPARTMENT—CITY OF BALTIMORE

49480

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Singer Ave ST.: 13 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merridith E. Norman.

(a) RESIDENCE. No. 718 Singer Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 24/1920.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
0	1	8	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work None ood

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md.

PARENTS

10 NAME OF FATHER Chas O. Norman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. "

12 MAIDEN NAME OF MOTHER Virginia Goodrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Chas O Norman

(Address) 508 Taylor st Catil Dr

15 Filed JAN 2 - 1921 ROBERT P. BRUCE Registrar Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 27th 1920, to Dec 31. 1920, that I last saw h.. alive on Dec 27th 1920, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H A Fales M. D.

1. 1924 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Mary 1 Hampden	1/3- 1921
20 UNDERTAKER	ADDRESS
J Walter Davis	3707 Paine St

N. B.—Blanks must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

49481

HEALTH DEPARTMENT—CITY OF BALTIMORE

49481

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Zile

(Residence in Baltimore: No. 20 Belclair Ave 15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, May 27, 1878.
(Month) (Day) (Year)

7-AGE, 42 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Chicago

PARENTS.

10-NAME OF FATHER, Jos. A. Greenhalch

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Mary Mc. Cabe

13-BIRTHPLACE OF MOTHER (State or Country), Kilkenny

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. N. Zile

(Address) 20 Belmar Ave.

15- Filed JAN 2 - 1921, 191.... ROBERT P. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ununited fracture right Humerus (automobile accident)
(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Pulmonary embolus 30 minutes
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 2, 1921 (Address) 2803 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death.....yrs.....mos. 2 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? On Belair Rd, Balto. County

Former or usual residence 20 Belmar Ave.

19-PLACE OF BURIAL OR REMOVAL, Chicago Ill

DATE OF BURIAL, Jan. 4, 1921

20-UNDERTAKER H. M. Routson

ADDRESS 2238 N. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

49482 HEALTH DEPARTMENT—CITY OF BALTIMORE 49482

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 E. Oliver ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna K. Posey

(a) RESIDENCE. NO. 2527 E Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos S. Posey

6 DATE OF BIRTH (month, day, and year) May 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Towson (State or country) Md

PARENTS

10 NAME OF FATHER Peter Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Agnes Posey (Address) 2527 E Oliver St

15 Filed JAN 2-1921 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1920, to Dec 31, 1920, that I last saw her alive on Dec 31st, 1920, and that death occurred, on the date stated above, at 9 4 m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Hospital Nurse 17 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Bernard J Ferry, M. D.

1/2, 1921 (Address) 9 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Maria Crm. Towson	1-4th 1920
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins sts

NOTE.—WRITE CLEARLY, with ink, and use only words fully spelled. AGE should be carefully supplied. PHYSICIANS should be mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49483.

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1616 W. Mulberry St ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Thomas

(a) RESIDENCE. No. 1616 W. Mulberry St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) House servant

(c) Name of employer Mrs. I.O.Wright

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Earnest Thomas (Son)
(Address) 1616 W. Mulberry St

15 DATE RECEIVED JAN 3 - 1921 ROBERT P. LATOUR Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, 19..., to Jan. 2 1921, 19...,
that I last saw her alive on Jan. 2, 1921, 19...,
and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Erysipelas complicated with Chronic parenchimatous Nephritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Neph.
(duration) 1 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? 3401 Clifton Ave

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter O. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	1/4/21 19
20 UNDERTAKER	ADDRESS
G B. Pye.	1026 E. Mulberry

N. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. PARTICULARS of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

0499484

HEALTH DEPARTMENT—CITY OF BALTIMORE

0499484

CERTIFICATE OF DEATH.

REGISTERED NO. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Johanna Progule

(Residence in Baltimore: No. *206 N. Green St. St.) Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec 25, 1897. (Month) (Day) (Year)

7-AGE. 23 yrs. mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Richard Klein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie M Evey.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Progule

(Address) 206 N Green St

15- JAN 3 - 1921 ROBERT B KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to Dec 31 1920, that I saw h[illegible] alive on Dec 31 1920, and that death occurred, on the date stated above, at 7 10 m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 31, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 3, 1921

20-UNDERTAKER [illegible] N. S. Ford

ADDRESS 1535 N Paca St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D49485 HEALTH DEPARTMENT—CITY OF BALTIMORE D49485

CERTIFICATE OF DEATH.

Monument St.

1-PLACE OF DEATH Louys Lane & Mon St. REGISTERED No. C 169

CITY OF BALTIMORE (No. 6 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Disall

(Residence in Baltimore: No. 304 N Bond. 4 10 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Col.	single

6-DATE OF BIRTH, Nov. (Month) 9 (Day), 1908 (Year)

7-AGE, 12 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country) Dorchester Co.

PARENTS.

10-NAME OF FATHER, Walter Dean

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co.

12-MAIDEN NAME OF MOTHER Ethel Cane

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Dean

(Address) 304 N. Bond St

15- Filed JAN 3 - 1921, 191... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

Accidental

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) J. E. Clarke M. D.
(Coroner)

12/31/20, 191... (Address) 1743 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Cambridge Md. DATE OF BURIAL, Jan. 3rd, 1920

20-UNDERTAKER Thos J. G. Locke ADDRESS 1302 Jefferson st

D49486 HEALTH DEPARTMENT—CITY OF BALTIMORE D49486

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 401 Woodlawn St. 39 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Willms

(Residence in Baltimore: No. 401 Woodlawn Road St.; 69 yrs. 9 mos. 0 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: About (Month) (Day), 1830 (Year)

7-AGE: About 70 yrs. ? mos. ? ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none 037
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Wolfgang Boehn

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Barbara Stofel

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Julia Wams (daughter)

(Address) 401 Woodlawn Road.

15- Filed JAN 3 - 1921, 191.... ROBERT P KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 30 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to, Dec 30 1920, that I saw h.. alive on Dec 27 191..., and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Asthma Edema 0040

(Duration) 5 yrs. ... mos. ... ds.

Contributory (SECONDARY) Arteriosclerosis (cause)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry F Coulby M. D.

Dec 30, 191.... [Address] 1 Court St K. City

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ---

Former or usual residence ---

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Jany 5, 1921.

20-UNDERTAKER: STEPHAN & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

terminal hemorrhage. not diabetic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Haemorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyaemia, Septicaemia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49487

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Park Ave. St.; 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Wheeler

(a) RESIDENCE. No. 1806 Park Ave. St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Caleb C. Wheeler

6 DATE OF BIRTH (month, day, and year) June 17-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne Md
(State or country)

PARENTS

10 NAME OF FATHER Frames Baston Morgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hillsboro Md

12 MAIDEN NAME OF MOTHER Julia A. Jump

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Queen Anne Md

14 Informant Gilbert E. Morgan
(Address) 1606 Park Ave

15 Filed ..... 19.... ROBERT E KRAUTER Registrar

JAN 3 - 1921 Burial P... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec 1~~, 1920, to Jan 1, 1921, that I last saw her alive on Jan 1, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 7, 19

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) J. D. Holland M. D.

. 19 (Address) 1624 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hillsboro Caroline Co Md	Jan 3 1921
20 UNDERTAKER Harry W. Eblen	ADDRESS 1944 W. Northam

NOTICE should be stated EXACTLY. PHRASING ... mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D4 9488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49488

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 E 22 St ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E Edmunds Foster

(a) RESIDENCE. No. 23 E 22nd St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ E E Foster

6 DATE OF BIRTH (month, day, and year) Sept 2 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53.	3	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship Official

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cape May U S

PARENTS

10 NAME OF FATHER Reuben Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape May

12 MAIDEN NAME OF MOTHER E E Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape May N J

14 Informant E E Foster

(Address) 23 E 22nd St

15 JAN 3 - 1921

ROBERT I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31st 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Dec 31, 1920, that I last saw h~~im~~ alive on Dec 31, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Wm T. Watson, M. D.

Dec 31, 1920 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 3rd 1921
20 UNDERTAKER	ADDRESS
Jenkins & Sons Co	Mt Holly N J

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1462 D 49489

1462 D 49489

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Houston

(a) RESIDENCE. No. 16 E Biddle St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2m yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10 NAME OF FATHER Rev. S Arthur Houston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Dorothea Rothenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Record (Address) J. H. H.

15 Filed JAN 3 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2- 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26- 1920, to Jan 2- 1921, that I last saw h.e alive on Jan 2- 1921, and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) - yrs. - mos. 10 ds.

CONTRIBUTORY (Secondary) Mastoid

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12/26/20.

Was there an autopsy? Yes.

What test confirmed diagnosis? Lumbar puncture. Horton Casparis

(Signed) W Davison, M. D.

(Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Detroit Mich	1-3 1921

20 UNDERTAKER Herweg & Justice Sons Co

ADDRESS W Fillol Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 0494 90

CERTIFICATE OF DEATH.

6 137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cinderella Sisson

(a) RESIDENCE. NO. 134 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meredith F. Sisson

6 DATE OF BIRTH (month, day, and year) June 14/97

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER P. J. H. Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sumner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Meredith F. Sisson
(Address) 134 N. Washington

15 Filed JAN 3 - 1921 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan. 2, 1921, that I last saw her alive on Jan. 2, 1921, and that death occurred, on the date stated above, at 1.50 A. m.

The CAUSE OF DEATH* was as follows:

Myocardeal Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Puerperal Septicemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronushas, M. D.

1-2, 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield Md.	Jan 4 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Spec. 6-9-19—H. P. Co.—1000 Bks.

D449491 HEALTH DEPARTMENT—CITY OF BALTIMORE D449491

CERTIFICATE OF DEATH.

177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John George Schell

(a) RESIDENCE. No. 519 Columbia Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent. Salesman Store 166

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER George J. DeLeit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Larner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) New City Hospital Record Balto Md

15 Filed JAN 3 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec., 26, 1920, to Dec., 31, 1920

that I last saw him alive on Dec., 31, 1920,

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis OVER

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 519 Columbia Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack R. Morgan M. D.

1/1, 1921 (Address) New city Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan. 3rd 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always ~~the~~ same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Not from calculus.
From infection source
of which unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49492 HEALTH DEPARTMENT—CITY OF BALTIMORE L49492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 9

CITY OF BALTIMORE: (No. Washington Road & Sexton ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Martin

(a) RESIDENCE. No. Washington Road, Sexton ST., 25 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be shown—State TION is very important. See instructions on back of OCCUPA- certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
3	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Martin

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Klapp

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Richard Martin
(Address) Morrell Park Md

15 Filed JAN 3 - 1921 ROBERT J. [illegible]
Registrar
Board of Health of Balto

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1921, to Jany 2, 1921, that I last saw him alive on Jany 2, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) same

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo Lonkieffer M. D.

Jany 3, 1921 (Address) Morrell Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 3 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0449493 HEALTH DEPARTMENT—CITY OF BALTIMORE 0449493

CERTIFICATE OF DEATH

28

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1409 N La Fayette St. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas B. Foster

(Residence in Baltimore: No. 1409 N. La Fayette St. 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: White

4 COLOR OR RACE: Male

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Mar. 9, 1876 (Month) (Day) (Year)

7 AGE: 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Wm H. S. Foster

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maria English

13 BIRTHPLACE OF MOTHER (State or country): Balto.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hunna Howard

(Address) 1409 N. Lafayette Ave

JAN 3 - 1921

Filed ....., 191.... ROBERT E KRAUTER REGISTRAR

Burial Permit ISSUED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. 2, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Jan. 2 1921, that I saw h[illegible] alive on Dec 30, 1920, and that death occurred, on the date stated above, at 2:20a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intercalosis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Ethanectini

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herbert C Blake M. D.

Jan. 2, 1921 (Address) 1014 N La Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted. If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Jan 4, 19[illegible]

20 UNDERTAKER: Geo Scott

ADDRESS 1000 Fayette

449494 HEALTH DEPARTMENT—CITY OF BALTIMORE 449494

CERTIFICATE OF DEATH. X 175-002

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josie Scruggs

(Residence in Baltimore: No. 514 E. St Paul's Court St. (yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	widow

6-DATE OF BIRTH, July (Month) 13 (Day), 1847 (Year)

7-AGE, 53 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.? 000

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Geo L Locker

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Rebecca Humphries

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert F Scruggs

(Address) 1130 W Franklin St

15- Filed JAN 3 - 1921 ROBERT B. KRAUTER Registrar of Burial Permits

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General septicaemia + local peritonitis, due to abscess of Bartholin Gland removed Excision Duodenum Ulcer (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. mos. ds.

(Signed) James W Burton M. D. (Coroner.)

1/7 20, 191... (Address) 2 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Sparrows Point

Former or usual residence Sparrows Point

19-PLACE OF BURIAL OR REMOVAL, Cemetery Lawn Farrington Va. DATE OF BURIAL, Jan 3., 19.21

20-UNDERTAKER Geo J Smith ADDRESS 1000 N Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

82.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049495 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049495

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1020 Eastern Ave ST.: 3 WARD)

2-FULL NAME Dominick Patti

(a) RESIDENCE. NO. 1020 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) August 29 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	25	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer Infant

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Patti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Bruno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Louis Patti
(Address) 1120 Eastern ave

15 Filed JAN 3 - 1921 ROBERT F. HEATHER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Jan 2, 1921, that I last saw h alive on Jan 2, 1921, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Measles (Rash)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Macaluso, M. D.

, 19 (Address) 412 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	January 3 1921
20 UNDERTAKER	ADDRESS
Wendell Duffy & Son	3 E Lan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D499496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D499496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Linsion ST.: 14 WARD) REGISTERED NO. X 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lt/c. John Massie Payne

(a) RESIDENCE. NO. Warrenton Va. ST., WARD. Warrenton Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gentleman.

(b) General nature of industry, business, or establishment in which employed (or employer) 87

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Inman Payne.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary S. Massie.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant M. J. H. Payne.
(Address) Warrenton Va.

15 Filed JAN 3 - 1921 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1920, to Jan 3d, 1921, that I last saw h.. alive on Jan 2d, 1921, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

Syphilis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyloric Obstruction (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Warrenton Va.

Did an operation precede death? Yes. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) T. H. Hammbaugh. M. D.

Jan 3 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Warrington Va	Jan 3/21 19

20 UNDERTAKER Wm Cook ADDRESS 502 E. 40th ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D49497

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph T. Wright

(a) RESIDENCE. No. 1768 Grouch Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 24 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	yrs	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hosp. Records
(Address)

15 Filed JAN 3 1921 ROBERT B. ELLICOTT Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Jan 1, 1921, that I last saw him alive on Jan 1, 1921, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic brain disease. 0730

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests & laboratory findings

(Signed) E. C. Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 3 1921
20 UNDERTAKER	ADDRESS
Wm T. Hartley	84 Washington St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully made and all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049498 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 78

CITY OF BALTIMORE: (No. 2013 E. Chase ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Windom Beverly Johnson

(a) RESIDENCE. NO. 2013 E Chase ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) ~~WIFE of~~ Marrion Johnston

6 DATE OF BIRTH (month, day, and year) April 14-1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic 082

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Hortamor Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Marrion Johnston
(Address) 2013 E. Chase St

15 Filed JAN 3 1921 ROBERT J. LAUTER Registrar
Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Dec 31, 1920, that I last saw h~~im~~ alive on Dec 30, 1920, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Chr Bronchitis and Emphysema

(duration) some 5 or 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arter. Endo-Cardidis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) Robert W. Mifflin, M. D.

, 19 (Address) 2010 16 Madison Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 3rd 1921
20 UNDERTAKER	ADDRESS
Wm I. Hartley	815 Washington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049499

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049499

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Eager ST.: 7 WARD)

2-FULL NAME Edward Cole Hines

(a) RESIDENCE. NO. 1610 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Ann Hines

6 DATE OF BIRTH (month, day, and year) May 22, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Contracting firm

(c) Name of employer John J. Nelson

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Hines

11 BIRTHPLACE OF FATHER (city or town) Balto,

(State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Va,

(State or country)

14 Informant Sarah Ann Hines

(Address) 1640 E Eager St.

15 JAN 3 - 1921 ROBERT B. LEAUTER Registrar

Burial Permit Oleg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 2, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec, 10, 1920, to Jany 2, 1921

that I last saw him alive on Dec, 27, 1920

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) H. Fell Magness, M. D.

Jan 2, 19 21 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 5 '21
20 UNDERTAKER Henry Lutz	ADDRESS 1007 N. E

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49500 HEALTH DEPARTMENT—CITY OF BALTIMORE D49500

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Still.

(a) RESIDENCE. NO. Davis St Mills Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) January 2nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ood

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George W Gill

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Pearl F Lescalletti

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co Md (State or country) Maryland

14 Informant George W Gill (Address) Owings Mills Md

15 Filed JAN 3 — 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from January 2nd 1921, to January 2nd 1921, that I last saw him alive on January 2nd 1921, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Immaturity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? / Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) J. Morris Reese M. D.

Jan 3, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Grove Cemet	Jan 6th 1921

20 UNDERTAKER J. F. Ebert ADDRESS Residence Town

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49501 HEALTH DEPARTMENT—CITY OF BALTIMORE D49501

CERTIFICATE OF DEATH. X135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Peare F Gill

(a) RESIDENCE. No Owings Mills Maryland ST.. WARD. Owings Mills Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3, 1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Maryland Maryland.

PARENTS

10 NAME OF FATHER Frank Lescallett

11 BIRTHPLACE OF FATHER (city or town) Frederick Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Wenrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant George W Gill (Address) Owings Mills Md

15 Filed JAN 3 - 1921 ROBERT B KRANTZ Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2nd 1921

17 I HEREBY CERTIFY, that I attended deceased from January 2nd 1921 to January 2nd 1921, that I last saw her alive on January 2nd 1921, and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows:

Placenta Praevia

(duration) 3 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Shock and Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of January 2nd 1921

Was there an autopsy? No.

What test confirmed diagnosis? ?

(Signed) J Norris Reese M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Grove Cemetery	Jan 6 1921

20 UNDERTAKER J F Edwin ADDRESS Reisterstown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

049502 HEALTH DEPARTMENT—CITY OF BALTIMORE 049502

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 S Monford Ave St.; 1st WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Gillian Nicolaus

(Residence in Baltimore: No. 807 S Monford Ave St.; 58 yrs., 6 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July 2nd, 1862 (Month) (Day) (Year)

7-AGE, 58 yrs. 6 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... P. R. R. Co.

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Louis Nicolaus

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Lowenstein

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma F Nicolaus

(Address) 807 S Monford Ave

15- JAN 3 - 1921 ROBERT P BRUTER
Filed....., 191... Burial Permit Issued
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 1 — (Month) (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 7 1921, to Jan 1 — 1921, that I saw h— alive on Jan 1 — 1921, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of Liver —

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(Duration) yrs. 1 mos. ds.

(Signed) Wm O Bracken M. D.

Jan 3, 1921 (Address) 125 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Jan. 5th, 1921.

20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049503 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049503

CERTIFICATE OF DEATH. 92-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Linden Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Dalsemer

(a) RESIDENCE. NO. 2400 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Dalsemer

6 DATE OF BIRTH (month, day, and year): Aug 26/1848

7 AGE: Years 72 Months 4 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Natchez Miss.

PARENTS

10 NAME OF FATHER: Jacob Dalsemer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Mrs. Rutzler) (Address) 2400 Linden Av

15 Filed JAN 3 - 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1920, to Jan 2, 1921, that I last saw h.. alive on Jan 1, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation 5 years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bath Hebrew — DATE OF BURIAL: Jan 4 1921

20 UNDERTAKER: Dan Rondheim — ADDRESS: 718 N. McKeldin

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049504

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049504

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Barnes

(a) RESIDENCE. No. 1422 Fairmount ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	~~Married~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~~Harry Barnes~~ Single

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Willian Barnes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Savoy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JAN 3 - 1921 ROBERT B. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1920, to Dec. 30, 1920, that I last saw him alive on Dec. 30, 1920, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. J. Rigney, M. D.

12-30-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL Jan 3 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49505 HEALTH DEPARTMENT—CITY OF BALTIMORE D49505

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 Hayward Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Hiltner

(a) RESIDENCE. No. 705 Hayward Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie M. Hiltner

6 DATE OF BIRTH (month, day, and year) June 9. 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H Hiltner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lentz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Baltimore

14 Informant Mrs Jennie Hiltner
(Address) 705 Hayward Ave

15 Filed JAN 3 - 1921 19 ROBERT I KRAUTER Registrar
ROBERT I KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 — , 19 20, to Dec 31 , 19 20.

that I last saw h.. alive on Dec 31 — , 19 20.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) mos.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) C C Riechers M. D.

1/1/21 19 20 (Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	JAN 3 1921

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0499506 HEALTH DEPARTMENT—CITY OF BALTIMORE 0499506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 6. REGISTERED NO. 64

CITY OF BALTIMORE: (No. 802 Fort Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmaline Lutsche

(a) RESIDENCE. No. 802 Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo H. Lutsche

6 DATE OF BIRTH (month, day, and year) Feb 8, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Schachels

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Jacobs

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co
(State or country) Md

14 Informant Geo Schachels
(Address) 1530 N Bakr st.

15 Filed JAN 3 1921 ROBERT A LAZZELL Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1920, to Jan 1, 1921, that I last saw her alive on Dec. 31, 1920, and that death occurred, on the date stated above, at 9-40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Previous Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Phillip S. Fowler, M. D.

1/2 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL CEDAR HILL. DATE OF BURIAL JAN 4 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

049507 HEALTH DEPARTMENT—CITY OF BALTIMORE 172 049507

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Eagle St. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Friedman

(Residence in Baltimore: No. 2022 Eagle St aft St.; 30 yrs., / mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-[redacted] WIDOWED, or [redacted], (Write the word.) widow

6-DATE OF BIRTH, Dec (Month) 2 (Day), 1853 (Year)

7-AGE, 67 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Mordche Demowitz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Libba

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto

15- Filed JAN 3 - 1921, 191.. ROBERT I [redacted] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1920, to Jan 3d 1921, that I saw her alive on Jan 2d 1921, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Septic)

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cyclitis, Cholecystitis.

(Duration) yrs. 6 mos. ds.

(Signed) Jacob H. Friedenwald M. D.

Jan 3, 1921 (Address) 1517 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 2022 Eagle

19-PLACE OF BURIAL OR REMOVAL, Elmer Memorial Park

DATE OF BURIAL, Jan 5, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Balto

Jack Lewis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049508 1049508

CERTIFICATE OF DEATH.

REGISTERED NO. C 1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 Hanover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert a Ford

(Residence in Baltimore: No. 423 Hanover St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 18 (Day), 1920 (Year)

7-AGE, 0 yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....000....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Herbert a Ford

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Reba Shudden

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert a Ford

(Address) 423 Hanover

15-Filed JAN 3 - 1921, 191... ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1920, to Jan 2 1921, that I saw h[illegible] alive on Jan 2 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Crothers M. D.

Jan 2 1921 (Address) 3100 Hanover Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md

DATE OF BURIAL, 1/4, 1921.

20-UNDERTAKER P J Fahey & Sons

ADDRESS 318 Eighth St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, with ink. Use no abbreviations.

Spec.—8-24-14—M. & T.—2000 Eks.

D49509 HEALTH DEPARTMENT—CITY OF BALTIMORE D49509

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Ritter

(Residence in Baltimore: No. Phoenix, Md St.; yrs., mos. 5 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, September 1 (Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George Ritter

11-BIRTHPLACE OF FATHER (State or Country), Europe.

12-MAIDEN NAME OF MOTHER Stalter

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital

(Address) Lombard & Greene

15- Filed JAN 3 - 1921, 191... ROBERT B KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Jan 2 1921, that I saw h in alive on Jan 2 1921, and that death occurred, on the date stated above, at 0450 m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. mos. 4 ds.

(Signed) Cyrus F. Horine M. D.

Jan. 2, 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Luther Church Balto DATE OF BURIAL, Jan 3, 1921

20-UNDERTAKER W. C. Burks & Sparks ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

D49510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49510

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2049 Woodbury Ave ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victor R. Morrison

(Residence in Baltimore: No. 2049 Woodbury Ave St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 1 (Day), 1879 (Year)

7-AGE, 41 yrs. 8 mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, John L. Belchner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sarah Pifer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Morrison

(Address) 2049 Woodbury Ave

15- JAN 3 - 1921 ROBERT B KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 2 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 28 1920, to January 2 1921, that I saw her alive on January 1 1921, and that death occurred, on the date stated above, at 6-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4½ ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

Jan 3rd, 1921. (Address) 3429 Chestnut Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery | DATE OF BURIAL, Jan 4, 1921

20-UNDERTAKER A J Marshall | ADDRESS 353 Fulton

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49511 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49511

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 N Franklin ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pennington

(a) RESIDENCE. No. 845 N Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			12 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Louis Pennington

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dorothy Julius

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant (Address) Robert B. Harrison, 12-31, 1920

15 Filed JAN 3 - 1921, 19.... Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Dec 31, 1920, that I last saw him alive on Dec 31, 1920, and that death occurred, on the date stated above, at 11 o'clock a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Rane, M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1921 JAN 3

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49512 ✓ D.49512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Church Home & Infirmary ST.: 6 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Virginia Anne Boyd ST., WARD.

(a) RESIDENCE. NO. Aberdeen, Md (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22-1920

7 AGE 8 days | 0 Years | 0 Months | 8 Days | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Church Home & Infy. Baltimore Md.

PARENTS

10 NAME OF FATHER Wm E. Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) North East Md.

12 MAIDEN NAME OF MOTHER Clara Stenhaem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aberdeen Md.

14 Informant (Address)

15 Filed JAN 3 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Dec 30, 1920, that I last saw h.. alive on Dec 29, 1920, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

premature infant
marasmus

8 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ralph E Swarts, M. D.

, 19 (Address) Church Home & Infy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL JAN 3 1921

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

Check of certificates. See instructions on back of this is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49513 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49513

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 S Patterson Park ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sienkiewicz

(a) RESIDENCE. No. 513 S Patterson Park ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sienkiewicz

6 DATE OF BIRTH (month, day, and year) aug 15 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or empioyer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Kuc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Nowakowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Sienkiewicz 513 S Patterson Park ave

15 Filed 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Jan 2, 1921, that I last saw h[illegible] alive on Jan 2, 19[illegible], and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) [illegible] yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Findings

(Signed) H. P. Bunford, M. D.

1-3, 1921 (Address) 8001 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Jan 5 1921

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank St

Ruane

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49514 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49514

CERTIFICATE OF DEATH. 40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 Dolphin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Ruane

(a) RESIDENCE. NO. 741 Dolphin ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? all yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Sept. 26-1875

7 AGE 46 Years 3 Months 6 Days — If LESS than 1 day.....hrs. or.....min.

1875 — 42 X X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Ruane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cunningt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Joseph La Trelawn 741 Dolphin st

15 Filed JAN 3 - 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 1. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18th 1920, to Jan 1st 1921, that I last saw h— alive on December 24 1920, and that death occurred, on the date stated above, at 10 20 a m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Sarcoma of Mesentery & Liver

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Large tumor in abdomen

(Signed) Edward Duvall Dewell, M. D.

, 19 (Address) 2432 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 1-4-1921

20 UNDERTAKER: H. C. Brumbaugh Son — ADDRESS 517 N Belnord

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49515 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 79 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Owens

(a) RESIDENCE. NO. 1025 Wilmore Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alverta Picther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital

15 Filed JAN 3 - 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 13, 19 20, to January 2, 19 21, that I last saw h..er alive on January 1, 19 21, and that death occurred, on the date stated above, at 5:00 A..m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) V B Heyman, M. D.

1/2/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 3rd 1921
20 UNDERTAKER A Jones	ADDRESS 207 S Stricker

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-4—M. & T.—2000 Blks.

D.49516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49516

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.; 4 WARD) REGISTERED No. C 79

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Kane

(Residence in Baltimore: No. 612 E Pratt St) St.; (If non-resident give usual residence.) Unknown

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... (Month) Unknown (Day) ..... (Year) 1851

7-AGE, 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. H. Wetzke

(Address) 153 W Lombard St

15-

Filed ..... 191.... Robert P. Harrison, Registrar.

JAN 3 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1 (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/3 1920, to January 1 1921, that I saw h— alive on January 1 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hunt Cox M. D.

Jan. 1, 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 612 E Pratt St

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem DATE OF BURIAL, Jan. 3rd, 1921

20-UNDERTAKER Harry H Wetzke ADDRESS 153 W Lombard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY, WITH UNFADING INK. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49617 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 4951

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph K. Greenwell

(a) RESIDENCE. NO. 1005 Woodbourne ST., Govans WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male / Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5" 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED Retired Watchman. 062

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant & Miners"

(c) Name of employer Transportation Co

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md.

PARENTS

10 NAME OF FATHER Joseph K. Greenwell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co Md.

12 MAIDEN NAME OF MOTHER Mary Wise.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary's Co Md.

14 Informant Mrs L. Greenwell (Address) 1005 Woodbourne Ave Govans

15 Filed ....., 19..... Registrar

Robert F. Harrison
Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 19 20, to Jan 2, 19 21,

that I last saw h.. alive on Jan 2, 19....,

and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

Chronic Nephritis yrs. mos. ds.
(duration)

CONTRIBUTORY Uremia
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Urine Test

What test confirmed diagnosis?

(Signed) J W Van Woert M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Jany 4" 1921
20 UNDERTAKER Wm L Hartwell.	ADDRESS 2286 W Balto St

Missing

#D 49518

H. Wilton Simms

spec.—6-9-19—H. P. Co.—1000 Bks.

D.49519 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver Sts. ST.: 24 1108 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Wilton Simms

(a) RESIDENCE. No. 1426 Riverside Ave ST.: WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Simms

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 031

(b) General nature of industry, business, or establishment in which employed (or employer) B & O

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Alexanderia Simms

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Nicholls

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Dora Simms
(Address) 1427 Riverside Ave

15 Filed JAN 3 - 19 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—1—1921

17

I HEREBY CERTIFY, That I attended deceased from 12-31-, 1920, to 1-1-, 1921, that I last saw h.i alive on 1-1-, 1921, and that death occurred, on the date stated above, at 8 a.m. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 12-31-20

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) J. A. Chesney, M. D.

1-1-, 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 4th 1921
20 UNDERTAKER	ADDRESS 1039
E. Schloman & Son	Hanover St

CAUSE OF DEATH in plain terms. ... mation should be given. CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificate.

D.49520

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.49520

CERTIFICATE OF DEATH

64

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1427 Hanover ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henry Marsberger

(Residence in Baltimore: No. 1429 Hanover st St.: 65 yrs. 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH Jan (Month) 7 (Day), 1855 (Year)

7 AGE 65 yrs. 11 mos. 24 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Marsberger

11 BIRTHPLACE OF FATHER (State or country) Germy

12 MAIDEN NAME OF MOTHER Odelia Studler

13 BIRTHPLACE OF MOTHER (State or country) Ner. Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Marsberger

(Address) 1427 Hanover st

15 JAN 3 - 1921 Filed ....., 191.... Robert P. Harrison, REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 1st (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 4, 1920, to January 1st 1921.
that I saw him alive on January 1st, 1921.
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Interstitial Nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) W. H. Broadbeam M. D.

Jan 2, 1921. (Address) 1228 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cem | DATE OF BURIAL Jan 4th, 1921

20 UNDERTAKER E. Schloman & Son | ADDRESS 1034 Hanover st

N. B.-Every item of information should be carefully supplied. Every item should be properly classified. Even if it may be properly classified, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49521 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49521

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 N. Bethel ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Sitterding

(Residence in Baltimore: No. 1715 N. Bethel St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 8, 1855 (Month) (Day) (Year)

7-AGE, 65 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 06

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Sitterding

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin B. Fenby

(Address) 1223 N. Carolina st.

15- Robert F. Harrison,

Filed JAN 3 1921, 191....

Burial Permit Clerk. Registrar.

N.B.—Every item of CAUSE OF DEATH in plain terms, as full as possible, is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 3, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1920, to Jan. 3, 1921, that I saw him alive on January 2, 1921, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) —yrs. —mos. 5 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin B. Fenby M. D.

Jan. 3, 1921 (Address) 1223 N. Carolina St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Trinity Cemetery — DATE OF BURIAL. Jan. 6, 1921

20-UNDERTAKER E. Schloman Son — ADDRESS 1034 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49522 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49522

CERTIFICATE OF DEATH. REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 E.North Ave. ST.: 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Augustine Mitchell

(a) RESIDENCE. No. 212 E.North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov.28.1828

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER S.B.Roach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs.Margaret Bailey
(Address) 212 E.North Ave.

15 Filed JAN 3 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2;1921 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Jan 1, 1921, that I last saw h[illegible] alive on Jan 1, 1921, and that death occurred, on the date stated above, at 6;30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None needed

(Signed) Stanley McElroy, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 4 1921

20 UNDERTAKER H.C. Hughes ADDRESS 444 Broadway

No. [illegible] mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49523

114

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST.; 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. John R. Grace

(Residence in Baltimore: No. Baltimore & Dundalk aves, Dundalk, Md. St.; ... yrs., 1 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 10, 1855 (Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired 086
(b) General nature of industry, business, or estsblishment in which employed (or employer) ..... Farmer

9-BIRTHPLACE, (State or Country), Baltimore Co Md.

PARENTS.

10-NAME OF FATHER, John Grace

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Mary Boyd

13-BIRTHPLACE OF MOTHER (Stste or Country). Marylanda

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Lynch

(Address) Dundalk Md

15-

JAN 3 1921

Robert P. Harrison,
....., 191.....
Registrar.
Burial Permit Clerk.

Druid Ridge Cemetery Jan 4

N.B.—Entries must be made in plain letters. CAUSE OF DEATH in plain letters is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Jan 3 1921, that I saw him alive on Jan 3 1920., and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

5 min

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cholelithiasis

(Duration) ... yrs. ... mos. 15 ds.

(Signed) H. L. Noble M. D.

Jan 3, 1921 (Address) Church Home Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 15 ds. In the State 66 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Dundalk, Md

Former or usual residence Dundalk Md

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery DATE OF BURIAL, Jan 5., 1921

20-UNDERTAKER H E Hughes ADDRESS 424 N. Broadway

D.49524 HEALTH DEPARTMENT—CITY OF BALTIMORE D49524

CERTIFICATE OF DEATH. 103

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 611 Walbert. Ave ST.: 9 WARD) REGISTERED No. C.....
2-FULL NAME Geo. H Garretson (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. 611 Walbert. Ave. St. Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE, White
5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Widowed
6-DATE OF BIRTH, April (Month), (Day), 1895 (Year)
7-AGE, 16 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work Sabaer (b) General nature of industry, business, or establishment in which employed (or employer) 040
9-BIRTHPLACE, (State or Country), Balto

PARENTS.
10-NAME OF FATHER, E C Garretson
11-BIRTHPLACE OF FATHER (State or Country), Harford Co
12-MAIDEN NAME OF MOTHER S H Hawley
13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E Garretson
(Address) 611 Walbert Ave

15- Filed ..., 191... Robert P. Harrison, Registrar. ~~Burial Permit Clerk~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 2 (Day) 1921 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:
Acc Gastritis Acc
(Duration) yrs. mos. 1 hr ds.
CONTRIBUTORY (Secondary) Pt Lawson
(Duration) yrs. mos. ds.
(Signed) Geo. Edwin Blades M. D.
(Coroner.)
1/2 21 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Jan 4 1921
20-UNDERTAKER Deage J Ruth ADDRESS 1735 Hfd ave

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. Every item important. See instructions on back of certificate.

Had no teeth & ate turkey dressing

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D.49525 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49525

CERTIFICATE OF DEATH.

175-004

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Edmondson Ave Walnut Ave ST.; 28 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Catherine Miller

(Residence in Baltimore: No. 4100 Groveland Ave St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) divorced

6-DATE OF BIRTH, Aug. 20, 1858
(Month) (Day) (Year)

7-AGE, 62 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benj. Bracken

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eliz. A Miller

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Lockard

(Address) 1706 Ellamont St.

15- Filed JAN 3 1921, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest to be held (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Street car, accident
Instant death

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. J. T. Hennessy M. D.
(Coroner.)

Jan. 3., 1921 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery, DATE OF BURIAL, ..., 192..

20-UNDERTAKER ~~Kelly~~ Kelly & Love ADDRESS 1723 W. Lafayette Ave

N.B.—Every item of information should be carefully filled in, so that it may be complete and accurate. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

049526 HEALTH DEPARTMENT—CITY OF BALTIMORE 049526

CERTIFICATE OF DEATH.

X 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 226-N. High ST.: 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guosippe Talucci

(Residence in Baltimore: No. 226-N. High St.; yrs., / mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (*Write* the word.) Widower

6-DATE OF BIRTH, Oct. (Month) 27 (Day), 1868 (Year)

7-AGE, 52 yrs. 2 mos. 4 ds. If LESS than 1 day, ~~....hrs. or.....min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... on Street

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Guissippe Talucci

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Talucci

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Talucci

(Address) 226-N. High St.

15- Filed JAN 4 - 1921, 191.. ROBERT E KRAUTER Registrar

Burial Permit ~~Issued~~

N.B.—Every item of information should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease
Acute Mitral regurgitation
Last Year (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cardiac
(Duration) ...yrs. ...mos. ...ds.

(Signed) H. J. Ruby M. D.
(Coroner.)
Jan 3, 1921 (Address) 1057 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Italy

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 1/4/21, 19..

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735-Harford Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0049527

HEALTH DEPARTMENT—CITY OF BALTIMORE

0049527

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 223 W. Hill ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie H. Gray

(a) RESIDENCE. NO. 223 W. Hill ST., WARD. 22
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Howard Gray

6 DATE OF BIRTH (month, day, and year) Jan. 2nd 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jonas Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jonas Henry
(Address) 223 W Hill St.

15 Filed JAN 4 - 1921 ROBERT I KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11th, 1920, to Jan 2, 1921, that I last saw her alive on Jan 1st, 1921, and that death occurred, on the date stated above, at 5301 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Lues.

Several months
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ++++ Wasserman

(Signed) D H Lamell, M. D.

1/3, 1921 (Address) 140 W. Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lauderdale Ct	Jan 5 1921
20 UNDERTAKER	**ADDRESS**
N. L. Brown & Son	108 W. Monty

N. B.—[illegible] mation should be carefully [illegible] CAUSE OF DEATH in plain terms, so that [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lucy Perry.

049528 HEALTH DEPARTMENT—CITY OF BALTIMORE 049528

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S Sharp ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Perry

(a) RESIDENCE. No. 317 S. Sharp ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 041

(b) General nature of industry, business, or establishment in which employed (or employer) Launderess

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) La.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sarah Polk (Address) 317 S Sharp St

15 [illegible] JAN 4 - 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/1921

17 I HEREBY CERTIFY, That I attended deceased from 12/27/20, 19..., to 1/2/21, 19..., that I last saw ... alive on 1/1/21, 19..., and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows: over

Pulmonary Oedema

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Con

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lucy Bowley, M. D.

, 19 (Address) 9085 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 4 1921
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	308 W. Monty

N. B. ... mation should be carefully ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Probably due to a
lobar pneumonia.
No other abnormal
condition.

1049529 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049529

CERTIFICATE OF DEATH

1 PLACE OF DEATH 1918 Hanover St. 50

CITY OF BALTIMORE (No. [redacted] St. 8 WARD)

2-FULL NAME Mary E. Howard

(Residence in Baltimore: No. 1918 Hanover St. 50 St.; yrs., mos. ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, [redacted]

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) 2017 E. Bethel St.

15- Filed JAN 4 - 1921 ROBERT J. KRAUTER Burial Permit Clerk... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 / 24 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene

(Duration) yrs. mos. ds.

(Signed) G. C. Wade M. D. (Coroner.)

12/24/20, (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodberry — DATE OF BURIAL, Jan. 4, 1920

20-UNDERTAKER John W. Henderson — ADDRESS 1502 E. Monument

N. B.—Every item of information should be carefully [illegible] CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

1049530 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 217 S Spring ST.: 3 WARD) REGISTERED No. C 79

2-FULL NAME Mary Wright

(Residence in Baltimore: No. 217 S Spring)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

aged 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day), (Year)

7-AGE, 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Mary Powell

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wright

(Address) 217 S Spring

15- JAN 4 - 1921 Filed, 191 ROBERT B KRAUTER Registrar

N. B.—Every item of information should be given, so that it may be properly tabulated. CAUSE OF DEATH in plain terms, so that it may be properly classified and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month), 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Colitis

(Duration) yrs. mos. 1 wk ds.

(Signed) H. C. Grady M. D. (Coroner.)

1/2 1921 (Address) 1436 Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedmont DATE OF BURIAL, Jan 5, 1920

20-UNDERTAKER John W Henderson ADDRESS 1502 Edmonment

049531 HEALTH DEPARTMENT—CITY OF BALTIMORE 049531

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2004 Division ST.: 14 50 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Mabell

(Residence in Baltimore: No. 2004 Division St.; yrs., 3 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	single

6-DATE OF BIRTH, Sept. 27, 1920
(Month) (Day) (Year)

7-AGE, yrs. 3 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Verdell Mabell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Maggie Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Verdell Mabell

(Address) 2004 Division St

15-JAN 4 - 1921 ROBERT P. KRAUTER

Filed....., 191.... Burial Permit Clerk
Registrar.

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Dis.

(Duration)..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy M. D.
(Coroner.)

Jan 3, 1921 (Address) 2807 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan. 4, 1921

20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 Gay

Spec.—8-24-14—M. & T.—2000 Bks.

Pearaway.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0449532 0449532

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Chalk.

CITY OF BALTIMORE: (No. 1626 Chalk alley ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Virginia Banks (Pearaway)

(Residence in Baltimore: No. 1626 Chalk alley St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic servant
(b) General nature of industry, business, or establishment in which employed (or employer)..... General house work 070

9-BIRTHPLACE, (State or Country), Harford Co. Md.

PARENTS.

10-NAME OF FATHER, Benjamin Banks

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md.

12-MAIDEN NAME OF MOTHER Sticker Clarke

13-BIRTHPLACE OF MOTHER (State or Country), Prince Geo. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mozie Connery

(Address) 1626 Chalk alley

15- JAN 4 - 1921 ROBERT P. KRAUTER
Filed ....., 191.. Burial Permit Clerk
Registrar.

N.B.—Every item of information must be given in plain terms, as this CAUSE OF DEATH is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27- 1920, to Jan. 2 1921, that I saw her alive on Jan. 1- 1921, and that death occurred, on the date stated above, at 4-45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) —yrs. —mos. 8 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. McCarthy M. D.

Jan. 3-, 1921 (Address) 906 N. Fulton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Jan 7, 1921
20-UNDERTAKER Edward Ringgold	ADDRESS 1463 W. Lary

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049533 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049533

CERTIFICATE OF DEATH. 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1367 N Streeker ST. 15 WARD)

2-FULL NAME Infant D Blanche Mabel

(a) RESIDENCE. No. 1367 N Streeker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernest Gamble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Blanche Mabel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Blanche Mabel (Address) 1367 N Streeker St.

15 Filed JAN4-1921 ROBERT A. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1921

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan 2, 1921, that I last saw h[illegible] alive on Jan 2, 1921, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. V. Fitzgerald, M. D.

1/3. 1921 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan 4 1921
20 UNDERTAKER Edward Ringgold	ADDRESS 1463 Mary

N. B.—WRITE PLAINLY, with ink. All questions must be properly answered and information should be carefully supplied. Abbreviations should not be used in filling out this certificate, so that it may be properly understood. Particular attention is called to the CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Form.—6-9-19—H. P. Co.—1000 Blks.

1049534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1049534

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Patterson Park Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline L. Felber

(a) RESIDENCE. No. 110 S Patterson Park Ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon L. Felber

6 DATE OF BIRTH (month, day, and year) Oct 14 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Christian F. Schmidt

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Hartzer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Frederick L. Felber

(Address) 110 S. Patterson Park Ave

15 Filed JAN 4 - 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1921, to Jan. 2nd 1921, that I last saw h[illegible] alive on Jan 2nd 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis.

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. H. Magruder, M. D.

, 19 (Address) 1st. East Mead St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jan 5 1921
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St

N. B.—[illegible] mation should be [illegible] CAUSE OF DEATH in plain terms, so that [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

0495-35 HEALTH DEPARTMENT—CITY OF BALTIMORE 0495-35

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 S. Thirteenth St. Highlandtown 26 WARD)

2-FULL NAME Catherine Mary Wienhold

(a) RESIDENCE. NO. 620 S. Thirteenth ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lf yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER John G. Wienhold

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie J. Dornhauser

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant John G. Wienhold
(Address) 620 S. Thirteenth St

15 FILED JAN 4 - 1921 ROBERT I. KRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 31 1920, to Jan 2, 1921, that I last saw h[illegible] alive on Jan 2 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E Helen Henning, M. D.

1/3, 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Jan 4 1921
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be properly classified. Entire CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

L049536 HEALTH DEPARTMENT—CITY OF BALTIMORE L049536

CERTIFICATE OF DEATH.

167

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST.: V WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elda R. Cohen

(Residence in Baltimore: No. 1745 E. Lombard street 15 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 37 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country), Russia

PARENTS.
10-NAME OF FATHER, David Narmsley
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER Annie Dorf
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Lewis
(Address) 1411 E. Baltimore St.

15- ROBERT E. KRAUTER
Filed JAN 4 - 1921 191.... Burial Permit Registered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Injuries Accident
(Duration) ..... yrs. ..... mos. 1 day ds.
CONTRIBUTORY (Secondary) Shock
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) H. E. Blader M. D.
(Coroner)
1/4/21 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 1 ds. In the State 15 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
at Home
Former or usual residence 1745 E. Lombard St

19-PLACE OF BURIAL OR REMOVAL, New Rosedale
DATE OF BURIAL, Jan. 4th 1920
20-UNDERTAKER Jack Lewis
ADDRESS 1411 E. Balto St.

N. B.—Every item of information should be given, so that it may be properly recorded. Write plainly in ink. Use terms, so that it may be understood. In CAUSE OF DEATH in plain terms, so that it may be understood. In important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049537

1049537

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 E. Lanvale ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter J. W. Frank.

(Residence in Baltimore: No. 445 E. Lanvale St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Feb. 20 (Month) (Day), 1904 (Year)

7-AGE, 16 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... ——— job

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John S Frank

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Bertha F Rushmore

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha F. R. Frank

(Address) 445 E. Lanvale St.

15- ROBERT P. BEAUTER

Filed JAN 4 - 1921 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 3 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1920, to January 3 1921, that I saw him alive on January 2 1921, and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) — yrs. 5 mos. — ds.

(Signed) Chester Roland, M. D.

1-3-, 1921. (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Jan. 5th, 1921

20-UNDERTAKER Holland & Colt ADDRESS Gay & Biddle Sts

N.B.—Every item of CAUSE OF DEATH in plain terms, as important. See instructions on back of certificate.

ec.—6-9-19—H. P. Co.—1000 Bks.

049538 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049538

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1835 Baker Street. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Matthew Hartman.

(a) RESIDENCE. NO. #1835 Baker Street. ST., WARD. (Resident.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Abt60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? Abt60 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Elizabeth Hartman.

6 DATE OF BIRTH (month, day, and year) Jany-24-1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from the 086

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Manufacturing Industry.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? ? ? Germany.

PARENTS

10 NAME OF FATHER Henry Hartman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ? Germany.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ? Germany.

14 Informant Miss Anna Hartman (daughter) (Address) 1210 Harford Av. City.

15 Filed JAN4-1921 19.. Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 3 1921, that I last saw him alive on Jan 3 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

arterio selerosis — High blood pressure — Brights-disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1/4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W.S. Willett M. D.

1/3 1921 (Address) 2220 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan'y-5-1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain TION is very important. See instructions on back

0049539 Sliwinski 0049539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. CITY OF BALTIMORE (No.) Lester E. Gough, St.: 1175-00 Ward) REGISTERED No. C .....

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME. John P Sliwinski

(Residence in Baltimore: No. 2210 E Pratt St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male,	White,	Single,

6-DATE OF BIRTH. August (Month) 30- (Day), 1894. (Year)

7-AGE. 24 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor,
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE. (State or Country). Philadelphia, Pa.,

PARENTS.

10-NAME OF FATHER. John Sliwinski,

11-BIRTHPLACE OF FATHER (State or Country). Poland,

12-MAIDEN NAME OF MOTHER. Bronislawa Domijan,

13-BIRTHPLACE OF MOTHER (State or Country). Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sliwinski, (Father)

(Address) 2210 E. Pratt Street

15- Filed JAN 4 - 1921 191... ROBERT A. LEATHERBURY Registrar.

Burial Permit Issued

N. B.—Every item of information must be given, so that if may be important. See instructions on back of certificate. CAUSE OF DEATH in plain terms,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull;
Auto accident;
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock —
(Duration) ....yrs. ....mos. ....ds.

(Signed) Arthur F. Blake M. D.
(Coroner.)
12/31/20, 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary.	JAN 5 - 1921

20-UNDERTAKER	ADDRESS
W. F. Sudowske.	705 S. Ann

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049540 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 S Collington Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Figinski

(a) RESIDENCE. NO. 410 S Collington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? 25 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Figinska,

6 DATE OF BIRTH (month, day, and year) May ------1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day labor, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Martha Figinska,

(Address) 410 S. Collington Ave.

15 Filed JAN 4 - 1921 19 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Jan 2 1921

that I last saw her alive on Jan 2 1920

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Mc Donald, M. D.

Jan 2 19 (Address) 410 S Collington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
R. Stanislaus.	JAN 5 - 1921 19
20 UNDERTAKER M F. Sadowske.	ADDRESS 905 S. Am

...mation should be ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1049541 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Monroe ST. 20 WARD) REGISTERED No. C 130

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Elizabeth Gerhard

(Residence in Baltimore: No. 523 N. Monroe St.; 10 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 5th, 1888 (Month) (Day) (Year)

7-AGE, 32 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Adam Huber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louisa P.

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Huber

(Address) 4228 Stiles st W. Phila.

15- ROBERT P. KRAUTH

Filed JAN 4 — 1921 1921 ..... Registrar.

N.B.—Every... CAUSE OF DEATH in plain terms... important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 1st, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....1917 to Jan. 1st 1921, that I saw h[illegible] alive on Dec. 1st 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 8 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Valvular lesions of heart (Duration) 1 yrs. ? mos. ? ds.

(Signed) O. H. Hoffman M. D.

Jan. 1st, 1921 (Address) 2100 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	Jan. 5th, 1921

20-UNDERTAKER Wm. Huber Son ADDRESS 2803 Edmondson ave

Dec.—6-9-19—H. P. Co.—1000 Bks.

0499542

HEALTH DEPARTMENT—CITY OF BALTIMORE

0499542

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2141 Walbrook Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Clarke

(a) RESIDENCE. No. 2141 Walbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt Robert H Clarke

6 DATE OF BIRTH (month, day, and year) Mar 25 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Hickman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Everett

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Maggie G. Clarke
(Address) 2141 Walbrook Ave

15 Filed JAN 4 - 1921 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from ~~~~, 19 15, to Dec 31, 19 20, that I last saw h[er] alive on Dec 31, 19 20, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cy Carcinoma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J J Buxton, M. D.

1/3, 1924 (Address) 5301 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	JAN 4 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

mation should be given in answering each question. CAUSE OF DEATH in plain terms. Indefinite answers such as "Disease of Heart," "Cancer," "Consumption," "Fever," "Old Age," "Infirmity," are not sufficient. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Spikes D. 49543

049543

CERTIFICATE OF DEATH

REGISTERED NO. 37

1-PLACE OF DEATH Baylor Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST.: 20 WARD)

2-FULL NAME Rosa Spikes

(a) RESIDENCE. NO. 765 9½ Mitchell St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Spikes

6 DATE OF BIRTH (month, day, and year) July 29 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Gehring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Hiebler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Francis Spikes (Address) Spurrows Pt Md

15 Filed JAN 4 - 1921 ROBERT J. KRAMER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1920, to Jan 2, 1921, that I last saw h.r alive on Jan 2, 1921, and that death occurred, on the date stated above, at 8.30 P.

The CAUSE OF DEATH* was as follows:

General Paralysis (1 the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueta Infection, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith, M. D.

19 (Address) Baylor Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	JAN 5 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

mation should be given in plain terms, so that it can be understood. In stating CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Varons

0495-44

HEALTH DEPARTMENT—CITY OF BALTIMORE

0495-44

CERTIFICATE OF DEATH.

104-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital St.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Gordon Varons

(Residence in Baltimore: No. Nursery & Child's Hospital St.; ..... yrs., 3 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept. (Month) 5 (Day), 1920. (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 3 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Not Employed
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Varons

11-BIRTHPLACE OF FATHER (State or Country) Va.

12-MAIDEN NAME OF MOTHER Edna Buchannon

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George A. Hutton

(Address) Nursery & Childs Hospital

15- Filed JAN4-1921, 191.... ROBERT F. [illegible] Registrar

N. B.—CAUSE OF DEATH in plain terms. Causes of Death which may be the result of occupation are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Jan 2, 1921, that I saw him alive on Jan 1, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. J. Singleton M. D.

1/3/, 1921 (Address) 2002 E Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 3 mos. 14 ds. In the State ....yrs. 3 mos. 28 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Jan. 4, 1921.
20-UNDERTAKER George J. Smith	ADDRESS 600 W. Fayette St.

Marasmus due to some dietary decomposition
not premature

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"): *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Blks.

1949545 HEALTH DEPARTMENT—CITY OF BALTIMORE 1949545

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Stern

(Residence in Baltimore: No. Jefferson Maryland St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	—

6-DATE OF BIRTH, January (Month) 2 (Day), 1921 (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 4 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Morris Stern

11-BIRTHPLACE OF FATHER (State or Country), Roumania

12-MAIDEN NAME OF MOTHER Betty Schein

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore St

15- JAN 4 - 1921 ROBERT F KRAUTER

Filed ....., 191.... Registrar.

N. B. CAUSE OF DEATH must be plainly stated. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan 3, 1921, that I saw h alive on Jan 3, 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jack P. Greenberg M. D.

Jan 4, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Rosedale DATE OF BURIAL, Jan 4, 1921

20-UNDERTAKER Jake Lewis ADDRESS 1411 E Balto St

c.—6-9-19—H. P. Co.—1000 Bks.

D49546

HEALTH DEPARTMENT—CITY OF BALTIMORE

1202 D49546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 Ramsay st ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine V. Stephan

(a) RESIDENCE. No. 752 Ramsay st ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 10 mos. C ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry F. Stephan

6 DATE OF BIRTH (month, day, and year) March 19. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 837

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George Pizelews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Mershmann

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Mr. Harry F. Stephan
(Address) 752 Ramsay st

15 JAN 4 - 1921 19 ROBERT F. KRAUTHOFF
Burial Permit Clerk

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN. WRITTEN STATEMENT OF CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17

I HEREBY CERTIFY, That I attended deceased from May, 1920, to Dec 31, 1920, that I last saw h. alive on Dec 31, 1920, and that death occurred, on the date stated above, at 5 15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. C. Wiedeman, M. D.

, 19 (Address) 1702 Eutaw Pl Bal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 5 1920
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pres

ec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

049547 — 402 049547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 418 S Eden ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Vollrath.

(a) RESIDENCE. NO. 418 S. Eden ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Vollrath Sr.

6 DATE OF BIRTH (month, day, and year): June 18-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Andrew Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John M Vollrath Sr

(Address): 418 S Eden St

15 Filed JAN 4 1927, 19.... ROBERT I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2. 1927

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1926, to Jan 2, 1927, that I last saw h.. alive on Jan 1, 1927, and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

Asthenia, Coronary Thrombosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) A. Amy Gray, M. D.

4/1. 1927 (Address) 1308 W Mt Royal Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Jan 5 1927

20 UNDERTAKER: J. Kerwin & Co

ADDRESS: 2018 Pulaski

CAUSE OF DEATH in plain ... See instructions on back. TION is very important.

...c.—6-9-19—H. P. Co.—1000 Bks.

D49548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49548

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2828 E. Baltimore ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eva Bolster

(a) RESIDENCE. No. 2828 E. Balt. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bolster

6 DATE OF BIRTH (month, day, and year) Aug 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Rutterfush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Wm Krug
(Address) 2828 E Baltimore St

15 Filed JAN 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to Jan. 2, 1921, that I last saw her alive on Jan 1, 1921, and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 5 yrs (?) Symptoms 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? microscopic clinical

(Signed) A. L. Wilkinson, M. D.

1/2, 1921 (Address) Rosebury, Balt, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL Jan 5 1921

ADDRESS roof Oaklawn

20 UNDERTAKER John Henry & Co

CAUSE OF DEATH to be given by PHYSICIAN. See instructions on back. TION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

2049549 HEALTH DEPARTMENT—CITY OF BALTIMORE 2049549

CERTIFICATE OF DEATH. 9 127

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2102 Aiken ST.: WARD)

2-FULL NAME George Frederick Strohmann Jr.

(a) RESIDENCE. NO. 2102 Aiken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 30. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	5	

8 OCCUPATION OF DECEASED — 100

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George F. Strohmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Martha Sipes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Martha Sipes Strohmann
(Address) 2102 Aiken St.

15 Filed JAN 4 - 1921 ROBERT P. BEAUTLE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30 - 1920, to Jan. 3, 1921, that I last saw h im alive on Jan. 3, 1920, and that death occurred, on the date stated above, at 4 H. m.

The CAUSE OF DEATH* was as follows:

Hemoptysis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Circumcision - Post Operative Haemorrhage (duration) ... yrs. ... mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan. 2/21
no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar P. Saydrock, M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan. 5 1920
20 UNDERTAKER H. Gildemeister Sons	ADDRESS North Ave

CAUSE OF DEATH in plain terms; see instructions on back of Certificate. ATION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

1049550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 1049550

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Bay View Hosp. ST.: 20 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa H. Steib

(a) RESIDENCE. NO. 2120 Nichens Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years 85; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Bay View Hosp. Records

15 Filed JAN4-1921 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan 2, 1921, that I last saw her alive on Jan 2, 1921, and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:
Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia (Terminal) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests.

(Signed) Dr. S. C. Medairy, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Jan: 5 1921

ADDRESS 3109 Fredk: Ave:

20 UNDERTAKER: G. W. Dill

BEFORE DEATH in plain CAUSE OF DEATH is very important. See instructions on back of TION

Dec.—6-9-19—H. P. Co.—1000 Bks.

No. 49551

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 49551

CERTIFICATE OF DEATH.

5 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Wilson

(a) RESIDENCE. NO. 306 Fayette St. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Thomas Wilson

6 DATE OF BIRTH (month, day, and year): Dec. 1842 1842

7 AGE: Years 78 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know " "

14 Informant: Theresa Tuiler (Address) 2006 Homewood Ave.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk

JAN 4 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/4, 1920, to 1/4, 1921, that I last saw h[illegible] alive on 1/4, 1920, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? (duration) yrs. ..... mos. ..... ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucy O. Ridgely M. D.

1/4, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Joppa Md

DATE OF BURIAL: Jan 6 1921

20 UNDERTAKER: Williams & Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificate. ATTENTION is very important.

Dec. 6-9-19—H. F. Co.—1000 Bks.

0.49552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20.49552

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moore

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 26 1920, to December 30 1920, that I last saw h im live on December 29, 1920, and that death occurred, on the date stated above, at 9:50 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tabes dorsalis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann.

(Signed) [illegible], M. D.

12/30/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 6 1921

20 UNDERTAKER Commissioner Health

ADDRESS

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. Consult your family physician if necessary. This information is required in the interest of the living. CAUSE OF DEATH must be filled in. It is very important. See instructions on back of this certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49553

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49553

CERTIFICATE OF DEATH.

64

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Harris

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, JOHNS HOPKINS HOSPITAL

(Address) New City Hospital

15 Filed JAN 4 - 1921 Robert P. Harrisen, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 20, 1920 to January 2, 1921

that I last saw him alive on January 1, 1921

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Hypertension

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) W. H. Forman, M. D.

1/2/19 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Jan 4 19 21

20 UNDERTAKER Commissioner Health.

ADDRESS

Physical Permit Clerk

4

CAUSE OF DEATH in plain terms. See instructions on back of CERTIFICATE. This information is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

0.49554 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49554

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2125 Vine ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Reardon Jr

(Residence in Baltimore: No. 2125 Vine St. St.; ..... yrs., ... mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, Dec 20th (Month) (Day) 1920 (Year)

7-AGE, ... yrs. 1 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Reardon

11-BIRTHPLACE OF FATHER (State or Country), Balto - City

12-MAIDEN NAME OF MOTHER Emma Nagle

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Reardon

(Address) 2125 Vine St

15- JAN 4 - 1921 Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH is particularly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3 1921 (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Jan 3 1921, that I saw h[illegible] alive on Jan 3 1921, and that death occurred, on the date stated above, at 4.0 p. m.

The CAUSE OF DEATH* was as follows:

..... Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis Chr.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Howard Statum M. D.

1/4/21, 191... (Address) 2127 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Jan 5., 1921.

20-UNDERTAKER Austin Harley Son — ADDRESS 527 N Fulton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49555 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49555

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rialto Theatre ST.: North Ave. near Linden Av. WARD) 14 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Beck

(a) RESIDENCE. NO. 1925 Eutaw Place ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? All her life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 22nd 1859

7 AGE 61 Years 8 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER George Beck

11 BIRTHPLACE OF FATHER (city or town) Bavaria

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretta Weindel

13 BIRTHPLACE OF MOTHER (city or town) Bavaria

(State or country) Germany

14 Informant Richard H Tippett

(Address) ~~Robert P. Harrison,~~

15 Filed JAN 4 1921 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3d 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to Jan 1 1921, that I last saw her alive on Jan 1 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

CONTRIBUTORY (Secondary) cerebral hemmorhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓ (duration) yrs. mos. ds.

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D

1/3 19 21 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 1-5- 1921

20 UNDERTAKER Henry W. Jenkins & Sons Co ADDRESS Orchard & McCulloh

CAUSE OF DEATH to be filled in plainly. See instructions on back of Certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49556 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49556

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 Park Ave ST.: 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Forbes Underdale

(a) RESIDENCE. NO. 865 Park Ave ST., 11 WARD. Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna F Underdale

6 DATE OF BIRTH (month, day, and year) Sept 14 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	3		

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Electrical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) Richmond Virginia
(State or country)

PARENTS

10 NAME OF FATHER John Underdale

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emily Truett

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Mrs W Keller
(Address) 38 East Biddle Street

15 Filed JAN 4 - 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1917, to Jan 4, 1921, that I last saw him alive on Jan 4, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Woodbridge, M. D.

, 19 (Address) 38 East Biddle Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grace P E Cem Elkridge Md	1-5 1921

20 UNDERTAKER Henry W Jenkins & Sons Co ADDRESS McCulloh Orchard

CAUSE OF DEATH in plain terms. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49557

0.49557 HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49557

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Emmark Ave. Arlington 27 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin H. Baker

(a) RESIDENCE. No. Emmark Ave. Arlington 27 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank H. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Annie M. Akers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Frank H. Baker

(Address) Emmark Ave.

Filed JAN 4 1921, 19..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan. 3, 1921, that I last saw him alive on Jan 2, 1921, and that death occurred, on the date stated above, at 7 45 A. m.

The CAUSE OF DEATH* was as follows: Over

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) James S. Atchison, M. D.

19 (Address) 402 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hardi Chapel (Balto. Co.)	Jan. 5 1921
20 UNDERTAKER	ADDRESS
Horace Burace & Son	363 Hollins St

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Omit technical terms. Name contagious disease, if any, which prevailed in family. Fill out all items. Information is required by law. Physician's certificate of cause of death is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O-Kid.
by Dr. Hennessey
No other infection than
probably a cold.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49558

HEALTH DEPARTMENT—CITY OF BALTIMORE.

20.49558

John F. Johnson

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 7 WARD)

2-FULL NAME John Johnson

(a) RESIDENCE. NO. 535 N. Fulton Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lucinda Johnson

6 DATE OF BIRTH (month, day, and year) May 10-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Lurenza Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Macabee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John F. Hampshire

(Address) 3720 Elm Ave

15 Filed JAN 4 - 1921 16 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Jan 3, 1921, that I last saw h alive on Jan 3, 1921, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood urea

(Signed) J. W. Waterdale M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Jan. 5 1921

20 UNDERTAKER Horace Burgee & Son

ADDRESS 363 Hollins

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine back of certificates. TION is very important. See instructions on back of certificates.

D. 49559 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49559

CERTIFICATE OF DEATH.

156-001

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 638 N. Franklin St. 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. R. Maloney

(Residence in Baltimore: No. 638 N. Franklin St.; 18 yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be filled CAREFULLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Jan. 11, 1866 (Month) (Day) (Year)

7-AGE, 54 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor 186
(b) General nature of industry, business, or establishment in which employed (or employer)..... Renovator

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Michael Maloney

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Mary Maloney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Francis Maloney

(Address) 638 W. Franklin St

15- JAN 4 1921 Robert P. Harrison,

Filed....., 191..... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by illuminating gas 1½ hrs.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Durntion).....yrs.....mos.....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Jan. 4, 1921 (Address) 2802 E. Fairmount Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Jan. 7, 1921

20-UNDERTAKER H. M. Routson

ADDRESS 230 N. Green

D.49560 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49560

CERTIFICATE OF DEATH.

REGISTERED No. C 160

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Redmond

(Residence in Baltimore: No. 211 S Mount St.; 6/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, Feb 7, 1884
(Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer): D.T.I

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER, John Redmond

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Clara Gallinger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Redmond

(Address) 211 S Mount St

15- Robert P. Harrison,
Issued JAN 4 1921 191 Burial Permit Clerk Registrar.

N.B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from wounds in throat which severed the trachea, inflicted by gunshot wound by person unknown (Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Hemorrhage (Duration) yrs. mos. 1/2 ds.

(Signed) James McFadden M. D.
(Coroner.)

Jan 4, 1921. (Address) 700 Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1/2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 211 S Mount St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, 1-4, 1921

20-UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun & Hollins sts

...ec. 6-9-19—H. P. Co.—1000 Bks.

D.49561 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49561

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 861 Robey ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas H Sedgwick

(a) RESIDENCE. NO. 861 Robey ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dont Know 1887

7 AGE: 33 Years Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Piano Player 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas Sedgwick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary E Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): A F Sedgwick 1314 Ave.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,
Burial Permit Clerk.

JAN 4 1921

CAUSE OF DEATH to be plainly written. See instructions on back of this sheet. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Jan 3, 1921, that I last saw h... alive on Jan 2, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Pulm. Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Exam

(Signed) W Woodward, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Jan 5 1921

20 UNDERTAKER: Brown & Pentland

ADDRESS 1140 W Lexington St

Dec.—6-9-19—H. P. Co.—1000 Bks.

D.49562 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49562

CERTIFICATE OF DEATH. Raspeburg

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hamilton Ave near Hyde ST. 57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizia Cornes

(a) RESIDENCE. NO. Hamilton Ave ST. Raspeburg WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Cornes

6 DATE OF BIRTH (month, day, and year) Unknown 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country) Germany

PARENTS

10 NAME OF FATHER Peter Ravedge

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Henry Cornes
(Address) Raspeburg Md.

15 Filed Jan 4 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 2, 1921, that I last saw h.. alive on Jan 2 19 21, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocarditis and arterio Sclerosis yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Timmons, M. D.

Jan 3, 1921 (Address) 4706 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cornes Family Cemetery	Jan 5th 19 21

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fallstown Md.

CAUSE OF DEATH TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Blks.

D-49563 HEALTH DEPARTMENT—CITY OF BALTIMORE D-49563

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 913 Madison Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John O Jonson

(Residence in Baltimore: No. 913 Madison Ave St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... April ..... 3 ....., 1840
(Month) (Day) (Year)

7-AGE, 80 yrs. 6 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Brush Mfr.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Jonson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary E Forrell

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lizzie P Jonson

(Address) 913 Madison Ave

15 JAN 5 - 1921 Filed....., 191.....

ROBERT I KRAUTER
Burial Permit Clerk

CAUSE OF DEATH must be stated in every case, whether Physician was in attendance or not. Every question must be answered if possible. Omissions cause unnecessary correspondence. Be particular and write plainly. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January ..... 4 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1920, to January 4 1921, that I saw him alive on January 3 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Paralysis .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... A. C. Polk ..... M. D.

Jan. 4, 1921 (Address) 20 E Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Jan. 7, 1921

20-UNDERTAKER Geo J Smith

ADDRESS 1000 E Fayette St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

049564 049564

CERTIFICATE OF DEATH.

X 19 4 REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. R. Zimmerman St.; ..... yrs., ... mos. ..... ds.)

(Residence in Baltimore: No. Robinson Ind.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, (MARRIED) WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 11 (Day), 1878 (Year)

7-AGE, 12 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Construction Dept 086
(b) General nature of industry, business, or establishment in which employed (or employer) P&R Construction Co

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles J Zimmerman

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md.

12-MAIDEN NAME OF MOTHER Mary Seymour

13-BIRTHPLACE OF MOTHER (State or Country), Fr. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis S. Zimmerman

(Address) Robinson Md

15- Filed JAN 5 - 1921 ROBERT I KRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1920, to Jan 3 1921, that I saw him alive on Jan 3 1921, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Decompensation

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) A. C. Geyer M.D.

Jan 3, 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 24 ds. In the State 42 yrs. 6 mos. 23 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Robinson Ind.

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery DATE OF BURIAL, Jan 5, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St

CAUSE OF DEATH must be stated in accordance with the International Classification of Diseases, Injuries and Causes of Death. See instructions on back of certificate. Information in answering questions 16 to 20 is important.

Spec.—8-24-14—M. & T.—2000 Bks.

049565 HEALTH DEPARTMENT—CITY OF BALTIMORE 049565

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 505 Greenmillen St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henriette Larkins

(Residence in Baltimore: No. 505 Greenmillen St.; 11 yrs., — mos. — ds.)
Balto

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, ...Unknown...., 1866
(Month) (Day) (Year)

7-AGE, 54 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private Family

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Jenkins

(Address) 505 Greenmillen

15- JAN 5 - 1921 Filed....., 191.. ROBERT I KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...January....3...., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1920, to Jan 3 1921, that I saw her alive on Jan 1921, and that death occurred, on the date stated above, at 3 45 A m.

The CAUSE OF DEATH* was as follows:

1.-Bronchitis ovw

.....

.....

..... (Duration) ...yrs. 3 mos. — ds.

CONTRIBUTORY Hemorrhage Nasal
(Secondary) At irregular intervals

..... (Duration) ...yrs. 1 mos. ...ds.

(Signed) ....John D. King.... M. D.

Jan 4, 1921 (Address) 1425 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn | DATE OF BURIAL, ..., 191...

20-UNDERTAKER John H. Frazier | ADDRESS 142 W. Fayette St.

CAUSE OF DEATH must be stated in every case. Information required is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0049566 HEALTH DEPARTMENT—CITY OF BALTIMORE 0049566

CERTIFICATE OF DEATH. 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jacob Youse

(a) RESIDENCE. No. 1031 Myrtle Ave ST.. 17 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Youse

6 DATE OF BIRTH (month, day, and year) July 22nd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72.	5	9	

8 OCCUPATION OF DECEASED 047

(a) Trade, profession or particular kind of work Moulder (iron)

(b) General nature of industry, business, or establishment in which employed (or employer) Fremont Foundry

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Youse

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elmira Timms

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mary Youse
(Address) 1031 Myrtle Ave

15 Filed JAN 5 - 1921 ROBERT B KRAUTER Registrar
Burial Permit Given

CAUSE OF DEATH must be plainly stated. See instructions on back. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd 1920, to Jan 3rd 1921, that I last saw him alive on Jan 3rd 1921, and that death occurred, on the date stated above, at 4 P M. m.

The CAUSE OF DEATH* was as follows:

Endocarditis, Chronic,

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compression

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Garrison Morse, M. D.

1-4. 1921 (Address) 01 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	1/7/21
20 UNDERTAKER	ADDRESS
Geo A Farley Funeral Director	

049567 HEALTH DEPARTMENT—CITY OF BALTIMORE 049567

CERTIFICATE OF DEATH. 120

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 116 W. Pratt ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jamie Perkins St. 5 mos. ds.)

(Residence in Baltimore: No. 116 W Pratt

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Write the word) Midow

6-DATE OF BIRTH, June 5, 1915
(Month) (Day) (Year)

7-AGE, 0 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lobster D.
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, William Perkins

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Jane White

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hopler

(Address) 116 W Pratt St

15- Filed JAN 5 - 1921 19.... ESTHER S KRAUTER Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
.....
.....
..... (Duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Dilated Heart
..... (Duration) ..... yrs. ..... mos. 10 ds.
(Signed) James McPherson M. D.
(Coroner.)
Jan 4, 1921 (Address) Hoye Church

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Jan 7, 1921

20-UNDERTAKER, H M Cook ADDRESS W Pratt St

N. B.—Every DEATH in plain terms. CAUSE OF DEATH important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Bks.

049568 HEALTH DEPARTMENT—CITY OF BALTIMORE 049568

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W West ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Hammond

(a) RESIDENCE. No. 105 W West ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 07

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedoring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Augustus Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Alice Shutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Alice Scott (Address) 105 W West

15 Date JAN5-1921 ROBERT B KRAUSE Registrar Vital Records Clerk

CAUSE OF DEATH ... See instructions on back of this TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Jan 2, 1921, that I last saw him alive on Dec 31, 1920, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

1/5, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 5 1921

20 UNDERTAKER Samuel Stanley ADDRESS 578 N Eutaw

6-9-19—H. P. Co.—1000 Blks.

1049569 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049569

CERTIFICATE OF DEATH. 119

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1807 Falls Road ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Payne

(a) RESIDENCE. No. 1807 Falls Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlina Payne

6 DATE OF BIRTH (month, day, and year) May 2 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Mover.

(b) General nature of industry, business, or establishment in which employed (or employer) Selling furniture

(c) Name of employer Security Storage & Trust Co.

9 BIRTHPLACE (city or town) (State or country) Buckeystown Frederick Co. Md.

PARENTS

10 NAME OF FATHER Phillip Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington DC

12 MAIDEN NAME OF MOTHER Elizabeth Posey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buckeystown Md.

14 Informant Ruben Payne
(Address) 120 - W. 23rd St.

15 Filed JAN 5 - 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan 3, 1921, that I last saw h[illegible] alive on Jan 3, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma. Jan

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No. Date of Operated upon for Removal of one testicle 1911.

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H. Wright M. D.

1921 (Address) 1709 Pressman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cockeysville Md	Jan 6 1921
20 UNDERTAKER Samuel T Hensley	ADDRESS 578 N Bond St

CAUSE OF DEATH [illegible] TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

049570 HEALTH DEPARTMENT—CITY OF BALTIMORE 049570

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Prentiss ST.; 15 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Williams

(Residence in Baltimore: No. 1502 Prentiss St.; 9 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Dec (Month) 31 (Day), 1876 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. ..... mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Servant
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Montgomery Co. Md.

PARENTS.

10-NAME OF FATHER, Robert Powell

11-BIRTHPLACE OF FATHER (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER Julia Prettyman

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 1502 Prentiss St.

15-

Filed JAN 5 - 1921 ROBERT B KRAUTER Bd.....

Burial Permit Received

CAUSE OF ... important. See instructions on back of ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30 - 1920, to Jan 2 1921, that I saw h[er] alive on Jan 2 - 1921, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about one (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Cullen Tarbutt M. D.

Jan 3, 1921. (Address) 906 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Druid Hill Cem.	Jan 5, 1921
20-UNDERTAKER	ADDRESS
Powell & Young	5 E Biddle

049571 Jos. Stales 049571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 92

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1217½ Jefferson ST.: 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. Stales
(Residence in Baltimore: No. 1217½ Jefferson St.) (42 yrs., 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Nov. 26, 1878 (Month) (Day) (Year)

7-AGE, 42 yrs. 1 mos. 5 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country),

PARENTS.
10-NAME OF FATHER, Balto. Md.
11-BIRTHPLACE OF FATHER (State or Country), Unknown State. Md.
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lydia State
(Address) 1217½ Jefferson St.

15-
Filed JAN 5 - 1921 ROBERT B KRAUTER Registrar
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1-, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acute Pneumonia
(Pneumonia)
(Duration) 2 yrs. mos. 2 dys.
CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. ds.
(Signed) C. O. Stales M. D.
(Coroner)
1/1/21 191... (Address) 1436 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery
DATE OF BURIAL, Jan 5, 1921
20-UNDERTAKER Chas. H. Johnson
ADDRESS 246 N. Carey St.

N. B.—Every item of DEATH in plain terms. CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049572 HEALTH DEPARTMENT—CITY OF BALTIMORE 049572

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Orleans ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Davis

(Residence in Baltimore: No. 1105 Orleans St. Left yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Jan (Month) 11th (Day), 1880 (Year)

7-AGE, 40 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Farm products

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Alexander Davis

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Jenin

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Davis

(Address) 108 Orleans St.

15- Filed JAN 5 - 1921, 191.... ROBERT I KRAUTER Registrar. Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5th 1920, to Jan 3d 1921, that I saw him alive on Jan 3d 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

1. Cerebral hemorrhage
2.
3.
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(Duration) X yrs. mos. 1 ds.

(Signed) Bruce Hoadley M. D.

Jan 5, 1921. (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sinai Israel Cem. DATE OF BURIAL, Jan. 6, 1921.

20-UNDERTAKER Jas. Ennis ADDRESS 1411 E. Balto

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec.—8-24-14—M. & T.—2000 Bks.

249573 HEALTH DEPARTMENT—CITY OF BALTIMORE 249573

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2425 Mc Culloh ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Ghann

(Residence in Baltimore: No. 2425 Mc Culloh St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown (Month) (Day), 1877 (Year)

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 0.27

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Gutzel Raddin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I Ghann

(Address) 2425 Mc Culloh St

15-

Filed JAN 5 - 1921 ROBERT B KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 5 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1920, to Jan 4 1921, that I saw h[illegible] alive on Jan 4th 1921, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) yrs. mos. 1 ds.

(Signed) Benj. Kramer M. D.

Jan 5th, 1921. (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, Jan 5th, 1921.

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore St

Cases to be important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

049574 HEALTH DEPARTMENT—CITY OF BALTIMORE 049574

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1503 Jackson ST.; 7th WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Mitchell

(Residence in Baltimore: No. 1503 Jackson St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, 9 (Month) 18 (Day), 1846 (Year)

7-AGE, 74 yrs. 3 mos. 14 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hswk
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Samuel Meyers.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Gardiner

(Address) 1503 Jackson St.

15-

Filed JAN 5 - 1921, 191.. ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1920, to Jany 2, 1921, that I saw her alive on " " 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 5 wks mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(Duration) 5 wks mos. ds.

(Signed) J J Burlington M. D.

1/3, 1921. (Address) 102 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. | DATE OF BURIAL, Jan 5., 1921

20-UNDERTAKER W. H. Sloan | ADDRESS 428 N. Charles St.

Cross out words not important. See instructions on back.

ec.—6-9-19—H. P. Co.—1000 Bks.

1049575 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSP. #56 24 120 REGISTERED NO.....

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GEORGE SINCLAIR

(a) RESIDENCE. NO. US PUBLIC HEALTH SERVICE HOSP ST #56. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
35	Yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of Industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Edgar T. Rosenbrak Registrar
(Address) FORT MCHENRY BALTIMORE MD.

15 Filed JAN 5 - 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30. 1920, to Jan. 2. 1921, that I last saw him alive on Jan. 2. 1920, and that death occurred, on the date stated above, at 1120 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis chronic & Broncho Pneumonia.

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ---- (duration) ---- yrs. ---- mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests & Exam.

(Signed) Herman B. Payne, M. D.
Senior Surgeon.
, 19 (Address) US. PHS. HOSP. 56 Ft. Henry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Jan 5 1921
20 UNDERTAKER	ADDRESS
D. Levinson & Bro	1127 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 49576 — 91-089 — 2 49576

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N. Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Violet Ruben

(Residence in Baltimore: No. 1004 N. Stricker St. Yrs. Lfe, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, March 2 (Month) (Day), 1916 (Year)

7-AGE, 2 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Max Ruben

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Viola Crump.

13-BIRTHPLACE OF MOTHER (State or Country), Va

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

...mant) Mrs Bertha Ruben

...cas) 1004 N Stricker St

15- Filed JAN 1921, 191... ROBERT B. ELLIOTT Burial Permit Clerk Registrar.

N. B.—Every item of information should be given. CAUSE OF DEATH in ink. WRITE PLAINLY. See instructions.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 4 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2 1921, to Jan 4 1921, that I saw h.e alive on Jan 4 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

.....Bronchitis.....

..... (Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

..... (Duration) ...yrs. ...mos. 2 ds.

(Signed) Chas. C. McCarthy M. D.

Jan. 5, 1921 (Address) 906 N. Strieker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Wyslem Cemetery — DATE OF BURIAL. Jan 6 1921

20-UNDERTAKER Bertram Wolfe — ADDRESS 1723 N Lafayette Ave

D49577 HEALTH DEPARTMENT—CITY OF BALTIMORE D49577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1913 Guilford av St. 12 - WARD)

REGISTERED No. C 80

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. McLenahan

(Residence in Baltimore: No. 1913 Guilford av St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M.	W.	Married

6-DATE OF BIRTH, Sept 24 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Millinery

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER, Wm McLenahan

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sara Murray

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward F McLenahan

(Address) 1913 Guilford Ave

15-Filed JAN 5 - 1921, 191.... ROBERT B. KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH must be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrissey M. D.
(Coroner.)

Jan 3, 191.. (Address) 742 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount Cem. DATE OF BURIAL, Jan 6, 1921

20-UNDERTAKER William J Gore ADDRESS 1737 N Lafayette

...c.—6-9-19—H. P. Co.—1000 Bks.

049578 HEALTH DEPARTMENT—CITY OF BALTIMORE 049578

CERTIFICATE OF DEATH. X 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. J. B. Linich.

(a) RESIDENCE. No. 136 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Linich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Helen Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio.

14 Informant Hospital Record Mercy Hospital
(Address)

15 Filed JAN 5 - 1921 ROBERT I. CARTER Registrar

Burial Permit Oloed

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1921

17

I HEREBY CERTIFY, That I attended deceased from 12/31, 1920, to 1/5, 1921, that I last saw h[illegible] alive on 1/5, 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. D. Paul, M. D.

1921 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md. DATE OF BURIAL Jan 6-21

20 UNDERTAKER Gus A. Finley ADDRESS Sutton & Eighth

0499579 HEALTH DEPARTMENT--CITY OF BALTIMORE 28 0499579

CERTIFICATE OF DEATH

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2425 St Paul St.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harrison F. Cooper.

(Residence in Baltimore: No. 2425 St Paul St.; 30 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May 19, 1880 (Month) (Day) (Year)

7-AGE: 40 yrs. 7 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE (State or country): Baltimore Co Md

PARENTS

10-NAME OF FATHER: James H Cooper

11-BIRTHPLACE OF FATHER (State or country): Baltimore Co. Md

12-MAIDEN NAME OF MOTHER: Lida B. Trumbaugh

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James H. Cooper

(Address) 2425 St Paul St

15. JAN 5 - 1921 ROBERT B. IRAUTER REGISTRAR

Social Form II 1920

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 3, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1920. to Jan 3 1921.

that I saw him alive on Jan 3, 1920.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tubercul[osis]

Several years.
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Cardiac Failure

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Carroll Lockard M. D.

Jan 4, 1920 (Address) 42 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL ~~OR REMOVAL~~: Mt Olivet — DATE OF BURIAL: Jan 6, 1921

20-UNDERTAKER: Geo W Little — ADDRESS: 531 N Fremont Ave

N. B.-Every item of information should be given as accurately as possible, so that it may be properly entered on the certificate. State CAUSE OF DEATH in plain terms, so that it may be understood by the public generally. The date of death is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

41

0495 80

CERTIFICATE OF DEATH.

119 0495 80

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Belair Rd St., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L Heggel

(Residence in Baltimore: No. 1115 Belair Ave St.; 41 yrs., — mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 29, 1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo E Heggel

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary C Hecker

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie M. Heggel

(Address) 1115 Belair Rd.

15-

Filed JAN 5 - 1921, 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 4 1921, that I saw h alive on June 4 1921 and that death occurred, on the date stated above, at 12 05 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L Lore M. D.

6/5/21, 191... (Address) Southern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, June 6, 1921

20-UNDERTAKER Robert S. Sills ADDRESS 631 E Lexington St

Cross out words not important. See instructions on back.

6-9-19—H. P. Co.—1000 Bks.

49581

HEALTH DEPARTMENT—CITY OF BALTIMORE

49581

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris

(a) RESIDENCE. No. 408 Camden St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? 5 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years 32 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic 16

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Arizona

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records M.T.H.

15 Date received JAN 5 - 1921 ROBERT P. LATIMER Registrar

CAUSE OF DEATH. See instructions. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1920, to Jan. 3, 1921, that I last saw him alive on Jan. 2, 1921, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Cagney, M. D.

1-3-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 1-4 1921

20 UNDERTAKER John J Fields

ADDRESS 1100 N Lombard St

D49582 HEALTH DEPARTMENT—CITY OF BALTIMORE D49582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. REGISTERED NO. C 79

CITY OF BALTIMORE (No. Averlea St.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester A. Hall

(Residence in Baltimore: No. Averlea St.: yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Widow

6-DATE OF BIRTH. Oct. (Month) 9 (Day), 1838 (Year)

7-AGE. 82 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE. (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. James B. Hall

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Ann E. Cox

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Hearley

(Address) Overlea Md.

15-JAN 5 - 1921 Filed. 101. BURIAL PERMIT Given. ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach Duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

1-5, 1921 (Address) Govt. Asst.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	Jan. 6, 1921
20-UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md.

CAUSE OF DEATH must be stated. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Blks.

D.49583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49583

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bulger

(a) RESIDENCE. NO. Washington D.C. ST. 28 WARD. (Washington D.C.)
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)				
7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 Years	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk-Treasury Dept
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer U. S. Govt

9 BIRTHPLACE (city or town) Lockport
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Patrick Bulger
11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Ireland
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Records of Mt Hope Retreat
(Address) ~~Mt Hope Retreat, Baltimore,~~

15 Filed ... 19 Robert F. [illegible] Registrar
Burial Permit Clerk.

N5-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 . 1920 . to Jan 4th . 1921 .
that I last saw h 42 alive on Jan 3rd . 1921 .
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
abt (duration) 4 yrs. 0 mos. ds.
CONTRIBUTORY (Secondary) Senile Dimentia
abt (duration) 4 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington D C
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank J. Flannery . M. D
Jan 4th 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Washington D.C. Jan 5 19
UNDERTAKER STEWART & BOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

2.49584 HEALTH DEPARTMENT—CITY OF BALTIMORE 2.49584

154

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3643 Culver ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louise Stoeg

(Residence in Baltimore: No. 3643 Culver — St.: 72 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October 7th, 1839
(Month) (Day) (Year)

7-AGE, 81 yrs. 2 mos. 22 ds.

If LESS than 1 day, ... hrs. or ... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Florist 045
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany —

PARENTS.

10-NAME OF FATHER, Frederick Kellermann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margarette Schneider

13-BIRTHPLACE OF MOTHER (State or Country), Germany —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Stoeg

(Address) 4209 Massachusetts Ave.

15-

JAN 5 - 1921 Robert P. Harrison,
Dated ....., 191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1920 to Jan 4th 1921, that I saw her alive on Jan 3d 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Senility —

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Edw. Grenlhe M. D.

Jan. 5th, 1921. (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem.

DATE OF BURIAL, Jan. 7, 1921

20-UNDERTAKER C. W. Dill.

ADDRESS 3109 Frederick Ave.

CAUSE ... important. See instructions on back.

...c. 6-9-19 H. P. Co. 1000 Blks.

0.49585 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49585

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hearn.

(a) RESIDENCE. No. Ten Hills Balt Md. ST., ... WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ethel Hearn.

6 DATE OF BIRTH (month, day, and year) Oct 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Hearn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Tennor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant F. Lee Hearn
(Address) 3611 Springdale Ave

15 Filed JAN 5 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH. TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17 I HEREBY CERTIFY, that I attended deceased from Dec 26, 1920, to Jan 4, 1921, that I last saw him alive on Jan 4, 1921, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:
Streptococcic Sore throat.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Toxic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 4, 1921.

Was there an autopsy? No —

What test confirmed diagnosis? Clinical evidence.

(Signed) J. B. Round, M. D.

1-4, 1921 (Address) 904 N Schools Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 7 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N Patterson Park

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1449586 1449586

CERTIFICATE OF DEATH.

REGISTERED NO. C 126

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. Monument St ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Yakowitz St. 65 yrs., mos. ds.)

(Residence in Baltimore: No. 721 N Aisquith St

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1853 (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Presser
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 Eutaw St

JAN 6 1921

Filed 1601 9NVC, 191.. Burial Permit Issued. ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5th 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 3 1921, to Jan. 5, 1921, that I saw him alive on Jan. 5 1921, and that death occurred, on the date stated above, at 12 45 p m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cystostomy for acute Retention

(Duration) yrs. mos. 2 ds.

(Signed) Charles A. Levy M. D.

1-5-21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State 25 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 721 Aisquith St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, 1/6, 1921

20-UNDERTAKER Jack Levis

ADDRESS 1411 Eutaw St

important. See instructions on back

...—6-9-19—H. P. Co.—1000 Bks.

049587

HEALTH DEPARTMENT—CITY OF BALTIMORE

049587

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Gay ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Evelyn Hiebler

(a) RESIDENCE. NO. 910 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 14-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	13	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John B. Hiebler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nellie Proctor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Nellie Hiebler

(Address) 910 N. Gay St

15 FILED JAN 6 - 1921 ROBERT I KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH. ATTENDING PHYSICIAN OR CORONER TO FILL OUT MEDICAL CERTIFICATE. INFORMATION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 21- 1920, to Jan 3rd 1921.

that I last saw her alive on Jan 3rd 1921.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ethelbert Hemming M. D.

1/5, 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan. 7 1921
20 UNDERTAKER Henry Horst (Inc)	ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

0 49588

HEALTH DEPARTMENT—CITY OF BALTIMORE

0 49588

CERTIFICATE OF DEATH.

91 D 49588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Ridgely ST.; 21 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl E. Parker

(Residence in Baltimore: No. 1011 Ridgely St. St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 9 (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 28 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 1011 Ridgely St.

PARENTS.

10-NAME OF FATHER, William Howard Parker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Marie Marie Ertl

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Parker

(Address) 1011 Ridgely St

15- JAN 6 - 1921 ROBERT F. BAUER

Filed ....., 191. ..... Registrar.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1921, to Jan. 5, 1921, that I saw her alive on Jan. 5, 1921, and that death occurred, on the date stated above, at 4 p, m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

OVER

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY ..... (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. T. Dickey M. D.

Jan. 5, 191 21. (Address) 1421 Monroe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet

DATE OF BURIAL, Jan. 7/21 191...

20-UNDERTAKER M. M. Cook.

ADDRESS 502 E. Baltimore

...c.—6-9-19—H. P. Co.—1000 Bks.

049589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1262 049589

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Josephine ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jones

(a) RESIDENCE. NO. 634 Josephine ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fem	col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Jones

6 DATE OF BIRTH (month, day, and year) Jan 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Calvert Co., Md

PARENTS

10 NAME OF FATHER Augustus Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Roalla Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Harriet Hayward
(Address) 763 Vine St

15 Filed JAN 6 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3d 1921, to Jan 4th 1921, that I last saw her alive on Jan 4th 1921, and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary) Complete suppression of urine / Uremia (?) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. B. Evans, M. D.

, 19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 7 1921
20 UNDERTAKER	ADDRESS
Leonard Friedlander	114 N. Schroeder St.

CAUSE OF DEATH ... TION is very important. See instructions on ...

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D49590

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7. N. Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Bell

(a) RESIDENCE. NO. 7 N. Vincent ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvia Bell

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Sylvania Bell X
(Address) 7 N. Vincent

15 Filed JAN 6 - 1921 19 ROBERT B. LRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) January 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Jany 4, 1921, that I last saw h[illegible] alive on Jany 4, 1921, and that death occurred, on the date stated above, at 5.20 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senile Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Theo Koelemay M. D.

Jany 5 19 (Address) 3450 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Jan 7 1921

ADDRESS 114 N. Schroeder St

20 UNDERTAKER Brown & Freeland

CAUSE OF DEATH to be plainly written. See instructions on back of this CERTIFICATE. TION is very important.

6-9-19—H. P. Co.—1000 Bks.

1049591 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049591

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 W. Pratt, ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sophia McMullen

(a) RESIDENCE. No. 2524 W. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? 52 yrs. 7 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William H. McMullen

6 DATE OF BIRTH (month, day, and year) May 11 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer "

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Chas. H. Blunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Magdalena Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. H. McMullen (Address) 2524 W. Pratt St.

15 Filed JAN 6 - 1921 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH. This information is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Ap 3, 1920, to Jan. 4, 1921, that I last saw her alive on Jan 3, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conser M. D.

1/4, 1921 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London PK

DATE OF BURIAL 1/7 1921

20 UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

1499592 HEALTH DEPARTMENT—CITY OF BALTIMORE 1499592

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 2800 WARD)

2-FULL NAME Emma Jackson

(a) RESIDENCE. No. Formerly 1045 Marshall ST., Baltimore Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Mr. Jackson

6 DATE OF BIRTH (month, day, and year) 1863 about

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57 abt Years	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Formerly Factory work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Not Known by me.

(c) Name of employer not Known

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Russell

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) Howard Co

12 MAIDEN NAME OF MOTHER Helen McBoneal

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed JAN 6 - 1921 ROBERT J. KRUTZ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1921, to Jan 4th, 1921, that I last saw h[illegible] alive on Jan 3rd, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Melancholia

Abt (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Jan 4th, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	1/7 1921
20 UNDERTAKER	ADDRESS
J. H. McCully	130 E. Fort

LAST SPACE FOR INFORMATION is very important. See instructions on reverse side.

049593 HEALTH DEPARTMENT—CITY OF BALTIMORE 049593

CERTIFICATE OF DEATH.

H7

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 7062 Glover ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ert No. 18.)

2-FULL NAME Emma Hagland

(Residence in Baltimore: No. 7062 Glover st

46 9 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Mat None, 1 (Month) (Day) (Year)

7-AGE, 47 yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nurses wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mat Rose

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mat Rose

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Hagland

(Address) 706 S. Glover St

15- JAN 6 - 1921

Filed....., 191... COUNTERSIGNED Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 4, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(Duration) ....yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

1/5/21, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, First German Evangelical | DATE OF BURIAL, Jan. 6th, 1921

20-UNDERTAKER Wm. C. Miller | ADDRESS 2334 Jefferson

N. B.—Burial Permit will not be issued unless CAUSE OF DEATH in plain terms is given. All questions important. See instructions on back of certificate.

Rec. 6-9-19—H. P. Co.—1000 Blks.

049594

HEALTH DEPARTMENT—CITY OF BALTIMORE

049594

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 Hull ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. White.

(a) RESIDENCE. No. 1341 Hull ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garment Worker.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Erlanger & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James. W. White.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Eagleston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Anna J. Cloman (Address) 1341 Hull

15 Filed JAN 6 - 1921 ROBERT A. BRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920, to Jan. 3, 1921, that I last saw h[illegible] alive on Jan 2, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. T. Seabury, M. D.

1/4, 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan 6 1921
20 UNDERTAKER	ADDRESS
Wm J. E. Evans	Jan 1428 S. Broadway

CAUTION is very important. See instructions.

D49595 HEALTH DEPARTMENT—CITY OF BALTIMORE D49595

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1411-W. 36th St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Westcott

(Residence in Baltimore: No. 1411-W-36th St.)

(If under 1 day, hrs.; if under 1 mo., ds.; if under 1 yr., mos. & ds.; if 1 yr. or over, yrs. only.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Mt.	White	Widower

6-DATE OF BIRTH, ... (Month) Sept. (Day) ..... (Year) 1849

7-AGE, 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ..... N.J. 031

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Mc Westcott

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. H. Westcott

(Address) 418-Taylor Ave

15- Filed JAN 6 - 1921 191.... ROBERT J. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Jan. (Day) 4, (Year) 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. H. Grossell M. D. (Coroner.)

Jan 5 1921 (Address) 3032 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Millville N.J. DATE OF BURIAL, Jan 6 1921

20-UNDERTAKER Cohen Howarth Son ADDRESS Chestnut Ave

Cause of death must be stated in plain English. See instructions on back of certificate. Important.

ec.—6-9-19—H. P. Co.—1000 Blks.

D49596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49596

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Obert H Riley.

(a) RESIDENCE. NO. 2014 Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary B Riley

6 DATE OF BIRTH (month, day, and year) Aug 31 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47.	4.	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bundle inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer Bragers

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Henry Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Angela Riley

(Address) Towson Md.

15 Filed JAN 6 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Jan 4, 1921.

that I last saw h alive on Jan 4, 1921

and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of R. Kidney

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Sudden

(duration) yrs. mos. 4. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 30 20.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wm. H. Finnegan, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 8 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

CAUSE OF DEATH. TION is very important. See instructions

Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

D 49597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

642 D 49597

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1091 S Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Barnes

(Residence in Baltimore: No. 1001 S Robinson St.; 2 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Sept. 19, 1860 (Month) (Day) (Year)

7-AGE, 60 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Joshua Barnes

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie Rode

(Address) 1001 S. Robinson St.

15-

Filed JAN 6 1921, 191.. ROBERT J. KRAUTER Registrar.

important. See instructions on

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Jan 3 1921, that I saw h.. alive on Jan 3 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

(Duration) .....yrs. abt 15 mos. .....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) .....yrs. abt 6 mos. .....ds.

(Signed) L. C. D. Kaufman M. D.

1/5, 1921 (Address) 3431 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, National Cemetery. DATE OF BURIAL, Jan. 7, 1921.

20-UNDERTAKER Zirkler & Zirkler ADDRESS 1739 E. Eager St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49598 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 49598

8-09

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1345 Ramsey St. Ward 21)

2-FULL NAME Josephine Guglielli

(a) RESIDENCE. No. 1345 Ramsey St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Guglielli

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Dea

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Peter Guglielli
(Address) 1345 Ramsey st

15 Filed JAN 6 - 1921, 19.... ROBERT F. LEADER Registrar
Burial Permit Given

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 19 21, to Jan 6, 19 21
that I last saw h— alive on Jan 5, 19 21,
and that death occurred, on the date stated above, at 1 m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Probably Pertussis of long standing (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Anderson, M. D.

, 19 (Address) 1211 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Jan 6, 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca st

Dec.—6-9-19—H. P. Co.—1000 Bks.

D49599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D49599

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 704 Ensor St ST.: 4 WARD)

2-FULL NAME Sarah Williams

(a) RESIDENCE. No. 433 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Williams

6 DATE OF BIRTH (month, day, and year) Dec 1 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 021

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER William Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert Williams (Address) 433 Fremont St

15 Filed JAN 6 - 1921 ROBERT B. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1921

17

I HEREBY CERTIFY, That I attended deceased from December 18, 1920, to January 4, 1921, that I last saw her alive on January 4, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Heart + Complication Diseases.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Heart + Nervous Breakdown Complication Diseases (duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death? 433 N. Fremont St

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo W Kennard, M. D.

1-4-1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	Jan 6 1921

20 UNDERTAKER ADDRESS

George H. Holland 1631 W mts Hill ave

CAUSE OF DEATH. ATTENTION is very important. See instructions.

6-9-19—H. P. Co.—1000 Bks.

49600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49600

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Cleveland Ave ST.: 71 WARD)

2-FULL NAME Bryan C Hagadon

(a) RESIDENCE. NO. 1143 Cleveland Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 109

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bryan Hagadon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Jane Hagadon 1143 Cleveland Ave

15 Filed JAN 6 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5 1921

17 I HEREBY CERTIFY, That I attended deceased from December 1 19..., to January 5 19..., that I last saw him alive on January 5 19 21, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Orem M. D.

1-6-, 1921 Address 1127 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL Jan 8 1921

20 UNDERTAKER George J Smith

ADDRESS 1000 W Fayette St

Sitterding

Rec. 6-9-19—H. P. Co.—1000 Bks.

D49601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~Baltimore~~ St Agnes Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 18 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Sitterding

(a) RESIDENCE. NO. 1012 W. Franklin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 803

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Sitterding (Address) 1012 W. Franklin St

15 Filed JAN 6 - 1921 Registrar

TION is very important. See instruc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 5, 1921, that I last saw h.~~im~~ alive on Jan 5, 1921, and that death occurred, on the date stated above, at 5.15 A, m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr

Valvular Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Livingston M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	1-8-1921
20 UNDERTAKER H. B Cunningham	ADDRESS 517 N. Schroeder St

ec.—6-9-19—H. P. Co.—1000 Bks.

1049602 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049602

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Stork

(a) RESIDENCE. No. 36 N. Curley St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachsmith 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 6 - 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 29, 19 20. to January 4, 19 21.

that I last saw him alive on January 4, , 19 21.

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) P. Boorman, M. D.

1/5/, 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	1/7/ 1921
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore St.

...c.—6-9-19—H. P. Co.—1000 Bks.

049603 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049603

CERTIFICATE OF DEATH. 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 856 Raborg St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Coold

(a) RESIDENCE. NO. 856 Raborg St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word): Widow'

If married, widowed, or divorced HUSBAND of (or) WIFE of: Ast Known

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 79 Years | Months | Days | If LESS than 1 day, hrs. or min.: Dont Know'

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress'
(b) General nature of Industry, business, or establishment in which employed (or employer): 041
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Louis Mo'

PARENTS

10 NAME OF FATHER: Dont Know'

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Asst Supt 856 Raborg

15 Filed JAN 6 - 1921 19 Registrar: ROBERT P. PRICE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4- 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 st, 1921, to Jan 4, 1921, that I last saw her alive on Jan 3, 1921, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Don't Know'

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H K Gorsuch, M. D.

Jan 6, 1920 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 1/6/21

20 UNDERTAKER: W M Ranson — ADDRESS: 230 N Green St.

TION is very important.

...ec. —6-9-19—H. P. Co.— 1000 Bks.

1049604

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049604

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Jones

(a) RESIDENCE. NO. 1025 N. Eutaw St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Jones

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Pompey Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Matilda Sandwich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 6 - 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4th, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1920 to Jan. 4, 1921, that I last saw him alive on Jan. 4, 1921, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) disease Tuberculous Pott's

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Aigney, M. D.

1-5-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Jan 6 21

20 UNDERTAKER Mrs Robert A Udell ADDRESS 1925 Ashland Av

CAUSE OF DEATH is very important. See INSTRUCTION on ...

Rec.—6-9-19—H. P. Co.—1000 Bks.

049605 HEALTH DEPARTMENT—CITY OF BALTIMORE 049605

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Brown

(a) RESIDENCE. No. 610 W. Montgomery St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Instant yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 6 - 1921 ROBERT P. PRUTER Registrar Burial Permit Clerk

TION is very important. See

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1920, to January 3, 1921, that I last saw h im alive on January 2, 1921, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) R Thorman, M. D.

1/3/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Jan 7 1921
20 UNDERTAKER	ADDRESS
L. E. Brown & Son	1060 Montg St

c.—6-9-19—H. P. Co.—1000 Bks.

049606 HEALTH DEPARTMENT—CITY OF BALTIMORE 049606

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 502 Hilleman Alley St.; 27 WARD)

2-FULL NAME Harriet Glenn

(a) RESIDENCE. NO. 502 Hilleman al. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 65 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): — 070

(c) Name of employer: Mr. Glenning

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Wm Ely (Address): 502 Hilleman al.

15 Filed JAN 6 - 1921 ROBERT E LEAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 6, 1921, that I last saw h[illegible] alive on Jan 5, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. A. Arnick, M. D.

, 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct.

20 UNDERTAKER: D. L. Brown and Son, ADDRESS: 1060 W. Monto St.

DATE OF BURIAL: Jan. 9 19 21

TION is very important.

D. 49607

...ec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49607

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 W. Lanvale ST.; 16 WARD)

2-FULL NAME Sarah Almira Saville

(a) RESIDENCE. NO. 1101 W. Lanvale ST., 16 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? 78 yrs. 6 mos. 12 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) (Resident)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Alvin Saville

6 DATE OF BIRTH (month, day, and year): June 24 1842

7 AGE — Years: 78 Months: 6 Days: 12 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Andrew Merker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alsace-Lorraine. (France)

12 MAIDEN NAME OF MOTHER: Caroline Hisig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: W. O. Saville (husband)
(Address) 1101 W Lanvale St

15 Filed JAN 6 - 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to June 5, 1921, that I last saw h[er] alive on June 5, 1921, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Cancer Endometrium

Empyema

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardio Dilatation

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Jany 7/ 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

TION is very important. See instructions

ec.—6-9-19—H. P. Co.—1000 Bks.

0.49608 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49608

92-120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Carrollton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Leonidas Boyd

(a) RESIDENCE. No. 913 N. Carrollton ST., 16 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 16 ds. How long in U. S., If of foreign birth? 71 yrs. 1 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Boyd

6 DATE OF BIRTH (month, day, and year) Nov-19-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	16	

8 OCCUPATION OF DECEASED 008

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) Fertilizers

(c) Name of employer Guano Company.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jas. H. Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ? Maryland

12 MAIDEN NAME OF MOTHER Susan Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Maryland

14 Informant Mrs Ida Boyd. (wife)
(Address) 913 N. Carrollton Ave

15 Filed JAN 6 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5— 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12— 1920, to Jan 5— 1921, that I last saw him alive on Jan 4— 1920, and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia & Uremia
followed by inanitiation 24 days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis & Right Hemiplegia
(duration) about 3 years yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carlton McCook, M. D.

Jan 5 1921 (Address) 1107 Waverly St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jany 7 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49609

CERTIFICATE OF DEATH.

REGISTERED NO. C 8 18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalind Mary Butt

(Residence in Baltimore: No. 2233 E. Biddle St.; ..yrs., 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, November 1st, 1920. (Month) (Day) (Year)

7-AGE, ..yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ———
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John B. Butt

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Ina L. Trimble

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Butt

(Address) 2233 E. Biddle St.

15- JAN 6 1921, 19.. Robert P. Harrison Registrar.

Important. See instructions.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1920, to Jan. 5 1921, that I saw h.r alive on Jan 4 1921, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(Duration) ..yrs. ..mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) ..yrs. ..mos. ..ds.

(Signed) Edward E. Singewald, M. D.

1/6/, 19.1. (Address) 1113 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Jan. 7..., 1921.

20-UNDERTAKER William G. Schaefer

ADDRESS 816 Monument

Spec.—8-24-14—M. & T.—2000 Bks.

0.49610 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓0.49610

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 W Lanvale St. ST.; 16 WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. James H Ewing

Residence in Baltimore: No. 1604 W. Lanvale St. St.; 9 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dec 15, 1852
(Month) (Day) (Year)

7-AGE, 88 yrs. - mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Physician
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, John N Ewing

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Anna Wise

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva A Ewing

(Address) 1604 W Lanvale St

15- Robert P. Harrison,
AUG 1921 ....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 28 - 1920, to Jan 5 - 1921, that I saw h[illegible] alive on Jan 4 - 1921, and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 2 days
Arterial sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility & High Blood pressure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carlton M Cobb M. D.

Jan 6, 1921 (Address) 1167 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, National Cem. DATE OF BURIAL, Jan 8, 1921

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

Important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

0.49611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 49611

120

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 233 Dolphin ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George T. Bankins

(Residence in Baltimore: No. 233 Dolphin St.; 14 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, dont Know (Month) (Day), 1878 (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER George Bankins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E Thompson

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penn

15- JAN 6 1921, 191... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5th (Month) (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1921, to Jan 5 1921, that I saw h[illegible] alive on Jan 5 1921, and that death occurred, on the date stated above, at 2.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Otitis media

(Duration) yrs. mos. ds.

(Signed) Chas J. Kilby M. D.

Jan 6, 191... (Address) 320 Wilmot

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt DATE OF BURIAL, Jan 8th, 1921

20-UNDERTAKER Daniel Easton ADDRESS 916 Penn ave

Important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49612 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Pearl ST.; 17 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salonia Carson.

(Residence in Baltimore: No. 506 Pearl St.; 48 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, Not known, 1872
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Private

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not known.

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Not known.

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pearl ave

15- Filed JAN 6 - 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

important. See Instructions.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 4 1921, that I saw h er alive on Jan 4 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

..... (Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Probably Rheumatism

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) H. N. King M. D.

Jan. 5, 1921. (Address) 1 E. Fort Franklin ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem

DATE OF BURIAL, Jan 6, 1921

20-UNDERTAKER David Easton

ADDRESS 916 Pearl ave

...ec.—6-9-19—H. P. Co.—1000 Bks.

20.49613 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49613

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830½ Lemmon St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Warner

(a) RESIDENCE. NO. 830½ Lemmon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Brann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Warner
(Address) 830½ Lemmon St

15 Filed JAN 6 - 1921 19 Robert F. Harrison, Registrar
(Burial Permit Clerk)

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Jan 6, 1921, that I last saw h alive on Jan 6, 1921, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Lawlee, M. D.

Jan 6 1921 (Address) 1504 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 9 1921

20 UNDERTAKER David Eaton ADDRESS 966 Eutaw

...—6-9-19—H. P. Co.—1000 Blks.

20,49614

20,49614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (a) No. 603 Hillen St ST. 5 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Jos McGrath.

(a) RESIDENCE. No. 603 Hillen ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married
5a If married, widowed, or divorced HUSBAND of (or WIFE of): Nora McGrath
6 DATE OF BIRTH (month, day, and year): 2-10-1876
7 AGE: Years 44 Months 10 Days 25 If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Ireland
PARENTS
10 NAME OF FATHER: Thos McGrath
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Mary Conway
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland
14 Informant (Address): Nora McGrath 603 Hillen St

JAN 6 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-4 1921.
17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1921 to Jan 4 1921
that I last saw him alive on Jan 4 1921 at 8 40 m.
and that death occurred, on the date stated above, at 8 40 m.
The CAUSE OF DEATH* was as follows:
Oedema of Lungs
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary): Anasarca
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John Schwarzkopf M. D.
1920 W Lexington St
. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 7 1921
20 UNDERTAKER: William Cook	ADDRESS: 502 E. North Ave

TION is very important.

...—6-9-19—H. P. Co.—1000 Bks.

D.49613 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49615

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 1201 E. Fort Ave ST.: 9 WARD)

2-FULL NAME Christian G. Lottier

(a) RESIDENCE. NO. 1201 E Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Lottier

6 DATE OF BIRTH (month, day, and year) Dec. 23/69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Caspar Lottier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Lenning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant ..... (Address) 703 E Fort Ave

15 Filed JAN 6 - 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Jan 5, 1921, that I last saw h. alive on Jan 5, 1921, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry C. Hyde, M. D.

19 (Address) 1100 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn -	Jan 7 1921
20 UNDERTAKER	ADDRESS
Wm Cook	1122 N. Wm

...c.—6-9-19—H. P. Co.—1000 Bks.

D.49616 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49616

CERTIFICATE OF DEATH.

28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

...ITY OF BALTIMORE: (a) No. 2626 Frederick Av — ST.: 20 WARD)

...-FULL NAME Elizabeth E Felger

...) RESIDENCE. No. 2626 Frederick Av ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? ——yrs. —— mos. ——ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm F Felger

6 DATE OF BIRTH (month, day, and year): Jan 26 - 1859

7 AGE — Years: 61 — Months: 11 — Days: 8 — If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Hausman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Leitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm F Felger
(Address): 2626 Frederick Av

15 Filed JAN 6 - 1921, 19... Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Jan 3, 1921, that I last saw h[illegible] alive on Jan 3, 1921, and that death occurred, on the date stated above, at 11.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

What was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

Jan 6. 1921 (Address) 2687 Wrestens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Jan 7 1921

20 UNDERTAKER: F. B. Kuhlpert — ADDRESS: 22 N Fred'k Ave

Spec.—6-9-19—H. P. Co.—1000 Eks.

20.49617

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49617

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 S. Payson St. (Ward) 20

2-FULL NAME Augustus Joseph Hutte

(a) RESIDENCE. No. 205 S. Payson St. Ward. 20

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Rossing Hutte

6 DATE OF BIRTH (month, day, and year) Dec 14 1785

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) West Baltimore

(c) Name of employer Bank

9 BIRTHPLACE (city or town) (State or country) Australia

PARENTS

10 NAME OF FATHER Joseph Hutte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Australia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Australia

14 Informant Dora R. Hutte

(Address) 205 S. Payson St.

15 Filed ... 19 ... Robert F. Harris, M. D. Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1920, to Jan. 4, 1921, that I last saw him alive on Jan. 4, 1921, and that death occurred, on the date stated above, at 10:55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Cold

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Senility & Debility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. T. Dickey, M. D.

19 (Address) 14 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 7th 19 21

UNDERTAKER ... ADDRESS 1103 Hupp Bldg

Make CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

...c.—6-9-19—H. P. Co.—1000 Bks.

0.49618 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 S. Bond St. 3 Ward)

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kalwa

(a) RESIDENCE. No. 411 S. Bond St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) Aug 20-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wicenty Kalwa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Stankewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wincent Kalwa
(Address) 411 S. Bond.

15 Filed ..., 19...

JAN 6 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 6, 1921, that I last saw h... alive on Jan 6, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Pneu'y

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. J. Weber, M. D.

Jan 7, 1921 (Address) 412 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 7 1921

20 UNDERTAKER William Fallowski ADDRESS 1618 Eastern ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 49619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49619

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Farley

(Residence in Baltimore: No. ..... St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, August 6, 1858
(Month) (Day) (Year)

7-AGE, 62 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk 069
(b) General nature of industry, business, or establishment in which employed (or employer)..... Railroad

9-BIRTHPLACE, (State or Country), New York.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... W F Farley

(Address)..... Eagle Force Pk.

15- Robert P. Harrison,
Registrar.
Dated..... 191.....
Burial Permit Clerk.

Important. See Instructions.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 13 1920, to December 25 1920, that I saw him alive on December 25 1920, and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs - Toxemia - Arteria - Sclerosis - Senile Dementia

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration).....yrs.....mos. 12 ds.

(Signed) William F. Schwartz M. D.

Dec-26, 1920. (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 7 mos. 14 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, | DATE OF BURIAL, ... 191...

20-UNDERTAKER Commissioner Health. | ADDRESS

JAN 8

Dated JAN 6 1921

Morgue

...c.—6-9-19—H. P. Co.—1000 Bks.

20.49620 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 20.49620

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 E. Pratt ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ruth Gudgeon

(a) RESIDENCE. No. 607 E. Pratt ST., 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas H. Gudgeon

6 DATE OF BIRTH (month, day, and year) Nov. 31- 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto County Md

PARENTS

10 NAME OF FATHER John Corns

11 BIRTHPLACE OF FATHER (city or town) Ft Lincoln (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Ruth Corns

13 BIRTHPLACE OF MOTHER (city or town) Ft Lincoln (State or country) Baltimore Co

14 Informant Howard Gudgeon (Son) (Address) 602 S. Pratt St

15 Filed JAN 6-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1920, to Jan 4, 1921, that I last saw h.. alive on Jan 4, 1921, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic tubal nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) C. L. Lore, M. D.

1-5, 1921 (Address) 2701 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 7 1921
20 UNDERTAKER	**ADDRESS**
Peter Nicolaus	2046 East

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49621

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3621 Sycamore ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A Sowers

(a) RESIDENCE. NO. 3621 Sycamore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 4 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Arch Sowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cora Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Arch Sowers 3621 Sycamore St

15 JAN 7 - 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

TION is very important. Use

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1921, to Jan 6th, 1921, that I last saw h[illegible] alive on Jan 6th, 1921, and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B. A. Fellows, M. D.

1/6, 1921 (Address) 1127 Union Ave E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 7 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut ave

Spec.—8-24-14—M. & T.—2000 Bks.

49622 HEALTH DEPARTMENT—CITY OF BALTIMORE L49622

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 Mt Royal ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Christian Ehrenschall

(Residence in Baltimore: No. 1532 Mt Royal Ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 18 (Day), 1850 (Year)

7-AGE, 70 yrs. 5 mos. 18 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John C. Ehrenschall

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Heiden

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Helen Ehrenschall

(Address) 1532 Mt Royal Ave

15-JAN 7-1921 ROBERT E KRAUTER

Filed ..., 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 31st (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 20 1920, to January 31st 1921, that I saw him alive on January 31st 1921, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) — yrs. — mos. 10 ds.

(Signed) Thomas F. Steelman M. D.

Jan 6, 1921. (Address) 1227 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan. 7., 1921

20-UNDERTAKER Chas. E. Franck ADDRESS 807 Madison Ave

important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Heiland

049623 049623

CERTIFICATE OF DEATH.

1921 REGISTERED NO. C 049623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3720 Foster Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M Heiland

(Residence in Baltimore: No. 2837 Jefferson Ave St.; 69 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October (Month) 27 (Day), 1851 (Year)

7-AGE, 69 yrs. 2 mos. 8 dr.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Adam Goeller

(Address) 3720 Foster Ave

15- Filed JAN 7 - 1921 ROBERT E KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/4/21 191..., to 1/4/21 191..., that I saw her alive on 1/4/21 191..., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. 1 ds.

(Signed) H H Gunell M. D.

1/5/21, 191... (Address) 633-S-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 1 — 7th, 1921.

20-UNDERTAKER Wm Chas A G Rohde

ADDRESS 1800 Pennsylvania Ave

Important. See instructions on back.

...—6-9-19—H. P. Co.—1000 Bks.

49624 HEALTH DEPARTMENT—CITY OF BALTIMORE 49624

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 701 W Fayette ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Dehn.

(a) RESIDENCE. NO. 701 W Fayette ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Dehn.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework and

(b) General nature of industry, business, or establishment in which employed (or employer) Cook. 021

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Geo. A Hendegen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary. Muchs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Hendegan. (Address) Goldsmith Ind.

15 JAN 7 - 1921 ROBERT B KRAUTH Registrar

Burial Permit Oiest

TION is very important. Sec...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 th. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 5, 1921, that I last saw h... alive on Jan 5, 1921, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonic Edema (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J Harwood, M. D.

, 19 (Address) 1139 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C C.	1-8 1921
20 UNDERTAKER	ADDRESS
E and B Hale	112 E Lexington

...ec.—6-9-19—H. P. Co.—1000 Bks.

D49625 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D49625

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 N. Kenwood Av. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Seltzer

(a) RESIDENCE. No. 30 N. Kenwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced (Husband of) (or) WIFE of: Adam H. Seltzer

6 DATE OF BIRTH (month, day, and year) Dec. 2/55

7 AGE — Years: 65 — Months: — — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md, Adams

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Eugene Seltzer
(Address): 30 N. Kenwood

15 Filed JAN 7 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Jan 5, 1921.

that I last saw h[illegible] alive on Jan 0 - 1921.

and that death occurred, on the date stated above, at 10-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hunt Jndley, M. D.

, 19 (Address) 2938 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Jan 8 1921

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

TION is very important. See instruction

ec.—6-9-19—H. P. Co.—1000 Bks.

D49626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49626

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3525 Clairmont St. 26 WARD)

2-FULL NAME Mary E. Barnhart

(a) RESIDENCE. No. 3525 Clairmont St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Ulysis G. Barnhart

6 DATE OF BIRTH (month, day, and year): Aug 7/62

7 AGE — Years: 58 — Months: 4 — Days: 29 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: John Lockhuff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Ulysis Barnhart 3525 Clairmont

Filed JAN 7 - 1921 19 ROBERT F. KRAJTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 19 20 to Jan 5 19 21.

that I last saw h..... alive on ..... 19 .....

and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): none

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. H. Hartman M. D.

, 19 (Address) 919 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Jan 8 1921

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

CAUSE OF DEATH. TION is very important. See instructions on

6-9-19—H. P. Co.—1000 Bks.

D 49627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49627

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16 Valley View Ave. 26 WARD)

2-FULL NAME Catherine F. Bachmann

(a) RESIDENCE. NO. 16 Valley View Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced (or) WIFE of: Chas. E. Bachmann

6 DATE OF BIRTH (month, day, and year): Sept 25/87

7 AGE — Years: 33 — Months: 3 — Days: 10 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Anthony Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Armentt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Chas E. Bachmann 16 Valley View ave

15 Filed JAN 7 - 1921 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1920. to Jan 4, 1921.

that I last saw h alive on Jan 4-20 1921.

and that death occurred, on the date stated above, at 5 P.M. P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

Tracheitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Phthisis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chas Davis, M. D.

(Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: Jan 8 1921

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 49628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49628

CERTIFICATE OF DEATH.

91-D 49628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 3528 Greenmount Ave ST.: 12 WARD)

2-FULL NAME Johanna Hardy.

(a) RESIDENCE NO. 3528 Greenmount Ave ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 56 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Benjamin Hardy.

6 DATE OF BIRTH (month, day, and year) July 5- 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. ppb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stoya
(State or country) Germany.

PARENTS

10 NAME OF FATHER Louis Krüger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Korf

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mrs Chas A Boyle.
(Address) 3528 Greenmount ave.

15 Filed ..... 19 ROBERT P. BEATTY Registrar

JAN 7 - 1921 Serial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Jan 6, 1921, that I last saw h.. alive on Jan 5, 1921, and that death occurred, on the date stated above, at 9.30 9. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ....yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ....yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby, M. D.

1/6, 1921 (Address) 3521 Greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL Jan 9 1921

20 UNDERTAKER Louis Heinmann

ADDRESS 320 Broadway

Spec.—6-9-19—H. P. Co.—1000 Blks.

1149619 HEALTH DEPARTMENT—CITY OF BALTIMORE 1149619

CERTIFICATE OF DEATH. 10-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Montford ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Kuhn

(a) RESIDENCE. NO. 130 N. Montford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kuhn.

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Martin Kuhn
(Address) 1419 E. Lombard St.

15 Filed JAN 7 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30 1920, to Jan. 4, 1921, that I last saw him alive on Jan. 4, 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Acute)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cessagno, M. D.

Jan 5, 1921 (Address) 2314 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan 10 1921
20 UNDERTAKER Lilly & Son	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 44630 / L 49630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdalin Cecilia Lingemann

(Residence in Baltimore: No. 617 S Robinson St.; ..... yrs., ... mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. (Month) 22nd (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 15 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER, Henry Lingemann

11-BIRTHPLACE OF FATHER (State or Country). Germany Md

12-MAIDEN NAME OF MOTHER Annie Kensinger

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Lingemann

(Address) 617 S Fourth St

15-

Filed JAN 7 1921 19.. ROBERT N. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2nd 1921, to June 6th 1921, that I saw her alive on June 5th 1921, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows: Otitis

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Schwatka (M. D.

June 6th, 1921 (Address) 734 S Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem.

DATE OF BURIAL, Jan. 7, 1921.

20-UNDERTAKER Tilly and Zeile

ADDRESS 403 S. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Bks.

044963 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

044963 1

CERTIFICATE OF DEATH.

10-079

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Maryland Ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Kuhn

(Residence in Baltimore: No. 130 N. Maryland Ave St.; 58 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb. (Month) 14 (Day), 1873 (Year)

7-AGE, 77 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of Industry, business, or establishment in which employed (or employer)..... at home 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Leyh

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Kuhn

(Address) 1919 E. Lombard St

15-

Filed JAN 7 1921, 191..... ROBERT E. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30 1920, to Jan. 7. 1921, that I saw her alive on Jan. 6, 1921, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration).....yrs.....mos. 8 ds.

(Signed) Eugene L. Pessagno M. D.

Jan. 7...., 1921 (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem.

DATE OF BURIAL, Jan. 10., 1921

20-UNDERTAKER Jos. H. Zeiler

ADDRESS 403 S. Broadway

049632 HEALTH DEPARTMENT—CITY OF BALTIMORE 049632

15V

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 214 E. Federal ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No name - child of Catalina Hill Butler

(Residence in Baltimore: No. 214 E. Federal St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 7 or 8 hrs. If LESS than 1 day, ...yrs.....mos.....ds. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... no occ
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Julian Butler

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Catalina Hill

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catalina Butler

(Address) 214 E. Federal

15-
Filed JAN 7 - 1921, 191..... ROBERT B KRAUTER Registrar.
SPECIAL PERMIT

CAUSE OF DEATH important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions -
Probable result of difficult birth.
(Duration) Several hrs. days.
CONTRIBUTORY (Secondary) Term Newborn
(Duration) ....yrs.....mos.....ds.

(Signed) M. Kelly M. D.
(Coroner.)
Jan. 6., 1921 (Address) 1029 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER Commissioner Health.	ADDRESS JAN 6 - 1921

Morgue

FOR H. E. WOODALL

049633 HEALTH DEPARTMENT—CITY OF BALTIMORE 049633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 19 N. Frederick St.; 4 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Dunn

(Residence in Baltimore: No. 19 N. Frederick St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	M

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 30 about yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 084

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15- JAN 7 - 1921 Filed ....., 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 30 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease
Chronic Mitral Regurgitation
(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)
(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner)
Jan. 6., 1921 (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER Commissioner Health.	ADDRESS JAN 8 1921

Cause of death must be stated. See instructions on back of certificate. Important.

JOHNS HOPKINS HOSPITAL

Wm. H. WOODALL

Spec. 6-8-19—H. P. Co.—1000 Bks.

1049634

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049634

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Anderson

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) Denmark
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JAN 7 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 19 21

17

I HEREBY CERTIFY, That I attended deceased from December 31, 1920 to January 5, 1921.

that I last saw him alive on January 5, 1921.

and that death occurred, on the date stated above, at 1:10 P.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann.

(Signed) [illegible] M. D.

1/5/. 19 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

JAN 7 1921

Commissioner Health,

Per. Wm. E. WOODALL

This is very important. Be sure...

Dec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Lo 49635 — 49635 — 81 — 49635

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Schreiber

(a) RESIDENCE. No. 2149 Cecil Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. known mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie H. Schreiber

6 DATE OF BIRTH (month, day, and year) Nov 13 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Lubman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address) J. H. H.

15 Filed JAN 7 - 1921 ROBERT I. FEUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Jan 5 —, 1921, that I last saw h.. alive on Jan 5 —, 1921, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows: VSV

Aneurysm of aorta

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture into trachea ?

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. R. Mason M. D.

Jan 5, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Parks	Jan 8 1921

20 UNDERTAKER E. A. Wiedefeld & Son ADDRESS 501 E 22 St.

CAUSE OF DEATH must be filled in plainly. See instructions on back. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Wasserman test at Hopkins negative.

Dec.—6-9-19—H. P. Co.—1000 Bks.

20.49636 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49636

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 8 WARD)

2-FULL NAME George C Geis

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1506 Broadway ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Mabel Geis

6 DATE OF BIRTH (month, day, and year) Jan 6 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Ship

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J Geis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Elizabeth Lindenstuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm C Geis
(Address) 1304 N Enson

Filed Jan 7, 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1920, to Jan 5, 1921, that I last saw h~~is~~ alive on Jan 5, 1921, and that death occurred, on the date stated above, at 11.40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Chas Smith, M. D.

19 (Address) 4736 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Jan 8 1921
20 UNDERTAKER	ADDRESS
John Herwig & Co	200 E Oliver

c.—6-9-19—H. P. Co.—1000 Bks.

D.49637 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49637

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 17 S. Highland Ave ST.; 26 WARD)

2-FULL NAME Elizabeth Virginia Gaddy

(a) RESIDENCE. NO. 175 Highland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 27 1919

7 AGE: Years 1; Months; Days 9; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank T. Gaddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Carrie V. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Frank T. Gaddy)
(Address) 17 S. Highland Ave

15 Filed DEC 7-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7/21 19

17 I HEREBY CERTIFY, That I attended deceased from 1/1/21, 19..... to 1/7/21, 19....., that I last saw h[illegible] alive on 1/7/21, 19....., and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(duration) 0 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Dyspepsia Marasmus

(duration) yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Mimm, M. D.

1/7/21 (Address) 29 W Balto

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Jan 10 1921

20 UNDERTAKER: J Herrigo Co — ADDRESS: 2008 Eutaw

rec.—6-9-19—H. P. Co.—1000 Bks.

D. 49638 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49638

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1119 N. Dallas ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bonielia Thompson

(a) RESIDENCE. NO. 1119 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. Thompson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Blue Ridge Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Benj. Thompson (Address) 1119 N. Dallas St

15 Filed JAN 7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1920, to Jan. 5, 1921, that I last saw her alive on Jan. 5, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastro-intestinal cat.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M. D.

(Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Jan 9 1921

20 UNDERTAKER Chas S Bailey

ADDRESS 1421 Jefferson

TION is very important.

...c.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49639

45207
D. 49639

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Peters

(a) RESIDENCE. NO. 1323 Argyle Ave ST. City WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 22. 858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Wm Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Eliza Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JAN 7-1921, 19.... Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 27- 1920, to Jan 5 1921, that I last saw her alive on Jan 5 1921, and that death occurred, on the date stated above, at 10.28 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J K Macon, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dempster D.C.	Jan 8 1921
20 UNDERTAKER	ADDRESS
Samuel Hendry	578 N Bid

TION IS very important

...c.—6-9-19—H. P. Co.—1000 Bks.

D.49640 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 49640

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Davis

(a) RESIDENCE. NO. 223 W. Biddle st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Davis

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Henry Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Susan Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Records (Address) M. T. H.

15 Filed JAN 7-1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 21

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1920, to Jan. 5, 1921, that I last saw her alive on Jan. 5, 1921, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, x-ray

(Signed) J. Guy, M. D.

1-5-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lexington Ky.

20 UNDERTAKER Samuel Hawley

DATE OF BURIAL Jan 7 1920

ADDRESS 678 W Balto

Maurice Roache

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49641 ✓ D.49641

HEALTH DEPARTMENT—CITY OF BALTIMORE

92-079

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Roache

(a) RESIDENCE. NO. 726 - W Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dont Know 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Struction Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) Summerville Mass
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Marie Monahan
(Address) 726 W. Lexington st

15 Filed Jan 7 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 19 21, to Jan 6th, 19 21, that I last saw h. alive on Jan 6, 19 21, and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tertiary Syphilis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) Frank C Marino, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Mass	Jan 8th 1921
20 UNDERTAKER A. Jones	ADDRESS 207 S. Stricker st

TION is very important. See instructions on back.

N7-1921

Dec.—6-9-19—H. P. Co.—1000 Bks.

20.49642

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49642

CERTIFICATE OF DEATH.

10-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 E. Hoffman ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Anna Katherine Haines

(a) RESIDENCE. NO. 2517 E Hoffman ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24 1920

7 AGE: Years | Months: 5 | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Frank Hinds

11 BIRTHPLACE OF FATHER (city or town) Zanesville (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ella Brandau

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Mrs A. Haines

(Address) 2517 E Hoffman

I HEREBY CERTIFY, That I attended deceased from

Jan 4 1921, to Jan 6 1921.

that I last saw her alive on Jan 6 1921.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) U. L. Hebner M. D.

Jan 7 1921 (Address) 1301 N Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bucks County. DATE OF BURIAL: Jan 8 1921

ADDRESS Lafayette

20 UNDERTAKER E J Fanning & Son 1938 E Lafayette

JAN 7 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49643

D.49643

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 E. Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Preis

(Residence in Baltimore: No. 1715 E. Federal St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Sept. (Month) 10th (Day), 1836 (Year)

7-AGE, 84 yrs. 3 mos. 27 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker (retired)
(b) General nature of industry, business, or establishment in which employed (or employer): 617

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Wagner

(Address) 1715 E. Federal St.

15-

Filed JAN 7 1921, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 6 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 6 1921, that I saw him alive on Jan 5 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ... yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. Gill Hall M. D.

Jan 7, 1921 (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 8, 1921

20-UNDERTAKER E. J. Fanning Jan 1921

ADDRESS E. Lafayette Ave

D.49644

D.49644

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Patapsco ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Schwarz

(a) RESIDENCE. NO. 1704 Patapsco ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Schwarz

6 DATE OF BIRTH (month, day, and year) Mch 14-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward L. Schwarz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frances Schwarz (Address) 1704 Patapsco.

15 Filed JAN 7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Jan 5, 1921, that I last saw h[illegible] alive on Jan 4, 1921, and that death occurred, on the date stated above, at 6.30 [illegible] m:

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

CONTRIBUTORY (Secondary) Senility & fracture of femur. (duration) yrs. mos. 5 ds. (duration) yrs. mos. 15 ds. (covered)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Hampson, M. D.

1/6/21 (Address) 1 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Jan 8 1921

20 UNDERTAKER F. D. Hance & Son

ADDRESS 733 Hanover

TION is very important.

D.49645

D.49645

spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1163 W Hamburg ST.; 21 WARD)

2-FULL NAME Caroline E. Dolphin

(a) RESIDENCE. No. 1163 W. Hamburg ST., 21 WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josiah Dolphin

6 DATE OF BIRTH (month, day, and year) Nov 3-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Conrad Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Ortwine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Bond

(Address) 1163 W Hamburg.

15 Filed JAN 7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1923, to Jan 6, 1924, that I last saw h.. alive on Jan 4, 1924, and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows:

Senile Decay.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 7, 1924 (Address) 517 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 8 1924
20 UNDERTAKER	ADDRESS
F. G. Straus & Son	1039 Hanover St

THIS IS VERY IMPORTANT

ec.—6-9-19—H. P. Co.—1000 Blks.

D.49646 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49646

55-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 S High St ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Barona

(a) RESIDENCE. NO. 300 S. High St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Barona.

6 DATE OF BIRTH (month, day, and year) Oct. 30 - 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51.	2.	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon 043

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Barona

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Selvestrina Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Christina Barona 300 S High St.

15 Filed JAN 7-1921, 19.... Robert F. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Jan 5, 1920, that I last saw h— alive on Jan 4, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica (Probable)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Rhinitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Had no test.

(Signed) Henry Ryan Smith M. D.

1/7, 1920 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 7 1921
20 UNDERTAKER	ADDRESS
Wendell & Lippold	37 Light

Spec.—8-24-14—M. & T.—2000 Bks.

D.49647 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49647

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 640 W Lombard St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Newcomb

(Residence in Baltimore: No. 640 W Lombard St.; .....yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.)
F.	W.	Married

6-DATE OF BIRTH. November 5, 1920
(Month) (Day) (Year)

7-AGE. .....yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Newcomb

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Regina Marigold

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Newcomb

(Address) 640 W Lombard St

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit C...

JAN 7-1921

important. See instructions

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1921, to Jan 6 1921, that I saw h.. alive on Jan 1921, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia Nephritis

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Ernest Neudecker M. D.

1/8/21, 191... (Address) 20 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loose Dent. Cem	June 15, 1921.

20-UNDERTAKER Wendell & Zippel & Son ADDRESS 37 S Eutaw St

ec.—6-9-19—H. P. Co.—1000 Bks.

D.49648 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. 1879

CITY OF BALTIMORE: (No. Bay View Hosp. St.: 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Brown

(a) RESIDENCE. No. 1026 Vine St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) City Hospital Reports

15 Filed JAN 8-1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17

I HEREBY CERTIFY, That I attended deceased from October 27, 1920, to Jan 6, 1921, that I last saw her alive on Jan 6, 1921, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Presenile Dementia with Depression

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) G. C. Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Kent Co Md	Jan 8 19 21
20 UNDERTAKER	ADDRESS 114 N Howard St
Brown & Buckland	

...—6-8-19—H. P. Co.—1000 Bks.

D.49649 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49649

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 W. Wash ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Cole

(a) RESIDENCE. No. 125 W. West ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Cole

6 DATE OF BIRTH (month, day, and year) 1/5/1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	22		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm Elliot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Fannie Brooks (Address) 125 W. West St

15 Filed JAN 8 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/ 19 21

17

I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1920, to Jan 6th, 21, that I last saw h... alive on Jan 6th, 21, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Tbc. bowels

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lee Bowley, M. D.

1/7/ 19 21 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 9 1920
20 UNDERTAKER John H. Toadvine	ADDRESS 1742 Utica

ec.—6-9-19—H. P. Co.—1000 Bks.

D.49650 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49650

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S East Ave. ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Goodwin.

(a) RESIDENCE. No. 203 S East Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Goodwin

6 DATE OF BIRTH (month, day, and year) August 10-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 237

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Robert Goodwin (Address) 203 S East Ave

15 Filed JAN 8-1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1921, to Jan 6th, 1921, that I last saw h. alive on Jan 6th, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Schwatka, M. D.

Jan 6 1921 (Address) 734 S Edward ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W M Carmel Cemetery	June 8 1921
20 UNDERTAKER	ADDRESS
H. Sander & Son	170 Fleet St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49651

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Ridgewood Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Miller

(a) RESIDENCE. NO. 2006 Ridgewood Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper Miller

6 DATE OF BIRTH (month, day, and year) Oct 11 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr Graf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs Scheiben

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Mrs Theresa Cussick

(Address) 2004 Ridgewood Av.

15 Filed JAN 8 - 1921 19.....

Robert F. Harrison,
Registrar
Burial Permit Clerk.

TION is very important. State information

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany. 5 1921, to Jany. 6 1921, that I last saw her alive on Jany. 6th 1921, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma & Heart failure (duration) 14 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Schmidt M.D., M. D.

1/6, 1921 (Address) 1605 N. Wood av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 8 1921
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 N Wolfe ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.49652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49652

CERTIFICATE OF DEATH.

REGISTERED No. C 15 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A Roycot

(Residence in Baltimore: No. 1728 N Carey St.; 72 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 10, 18..... (Month) (Day) (Year)

7-AGE, 73 yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, ~~Unknown~~ John Roycot

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna S. Beckman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Roycot

(Address) 1728 N Carey St

15- Filed ..... 191..... Robert F. Harrison, Registrar. Burial Permit Clerk.

JAN 8 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 6 1921, that I saw h.. alive on Jan 6 1921, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) O S Lloyd M. D.

Jan 6, 1921. (Address) 22 32 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Louden Park	Jan 10, 1921.
20-UNDERTAKER	ADDRESS
Josiah Taylor	Hanover

Important

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.49653 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49653

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1725 E. Lanvale ST.; 8 WARD)

2-FULL NAME Lottie A. Neumiester

(a) RESIDENCE. NO. 1725 E Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Marr[illegible]

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Conrad C. Neumiester

6 DATE OF BIRTH (month, day, and year) April 11 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER George A. Voelkel
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Dora Walkling
13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs. George A. Voelkel
(Address) 1725 E Lanvale St

15 Filed ..... 19 [illegible] Registrar

JAN 8-1921

[illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1920 to Jany 7 1921
that I last saw h[illegible] alive on Jany 7 1921
and that death occurred, on the date stated above, at 9 A. ....m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY Cystitis
(Secondary) (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Laboratory
(Signed) J. H. Thomas M. D.
July 24 1921 (Address) 1328 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Lutheran Cemetery Pulaski	Jan 11 1921
20 UNDERTAKER	ADDRESS
Henry Hoch-Sr	1301 E Eager St

TION is very important. Fill out

D.49654 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49654

CERTIFICATE OF DEATH.

166

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josh Hospital St. 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances E. Trimmer

(Residence in Baltimore: No. 1637 N Patterson Park Ave St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, May 8, 1876.
(Month) (Day) (Year)

7-AGE, 44 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Julius Birkmaier

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Trimmer

(Address) 1637 N. Patterson Park Ave

15- Robert E. Hartman,

Filed ..... 1921 ..... [illegible] Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Clothes caught fire from fire in Parlor Stove (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner.)

....., 1921... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan. 10, 1921

20-UNDERTAKER Henry Hoecke & Son — ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Blks.

0.49655

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.49655

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 12 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Pickett

(Residence in Baltimore: No. 2727 Oak St also St.: 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Jan. (Month) 24 (Day), 1851 (Year)

7-AGE, 69 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Carroll Co. Md

PARENTS.

10-NAME OF FATHER, Not Known.

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frank Richards

(Address) 2727 Oak St

15-

Filed....., 191.....

Registrar.

Robert F. Harrison.

JAN 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1921, to Jan. 7 1921, that I saw h[e]r alive on Jan. 7 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ....yrs. ....mos. 21 ds.

(Signed) [illegible] M. D.

Jan. 7, 1921, (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2727 Oak St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 11, 1921

20-UNDERTAKER Henry Hoch & Sons

ADDRESS

Important.

20.49656 HEALTH DEPARTMENT--CITY OF BALTIMORE 20.49656

CERTIFICATE OF DEATH

REGISTERED No. C 142

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1822 E Fairmount Ave ST.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celia Sacks

(Residence in Baltimore: No. 1822 E Fairmount Ave St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH Unknown (Month) (Day), 1825 (Year)

7-AGE 95 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ood

9-BIRTHPLACE (State or country) Russia

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Lewis

(Address) 1411 E Balto St

15

JAN 8 - 1921 Robert P. Harrison, 191

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January (Month) 7 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan 7 1921, that I saw h-ex alive on Jan 7 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(Duration) yrs. mos. 7 ds.

Contributory (SECONDARY) old age (Exhaustion)

(Duration) yrs. mos. ds.

(Signed) Meyer Ephraim M. D.

Jan 7, 1921 (Address) 1904 E Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State 35 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1811 E Fairmount

19-PLACE OF BURIAL OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Jan 8, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

N.B.—To secure intelligent registration, state CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Every question is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49657 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Curley St.; 6 Ward) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa C. Paulus

(a) RESIDENCE. No. 404 N. Curley St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Paulus

6 DATE OF BIRTH (month, day, and year) Dec 11 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Gottlieb Wieland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Walter Paulus
(Address) 404 N. Curley St

15 Filed 19 Robert P. Harrison, Registrar

N8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/21 19

17 I HEREBY CERTIFY, That I attended deceased from 1/5/21, 19..., to 1/6/21, 19...,
that I last saw her alive on 1/6/21, 19...,
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frederick H. Gorman, M. D.

1/7/21 (Address) 7919 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1-8- 1921
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Balto St.

ec.—6-9-19—H. P. Co.—1000 Blks.

D. 49658 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49658

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2523 Hollins ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wenth

(a) RESIDENCE. No. 2523 Hollins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Wenth

6 DATE OF BIRTH (month, day, and year) July 12-1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
46	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Wenth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Seibert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pauline Wenth (Address) 2523 Hollins St

15 Filed Aug 8-1921 Robert P. Harrison, Registrar [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/1 1920, to 1/5 1921, that I last saw h.... alive on 1/5/21, 19..; and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) J. Chastonton, M. D.

(Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 8 1921
20 UNDERTAKER	ADDRESS
H. D. Neipert	2236 Frederick Ave

...ec.—6-9-19—H. P. Co.—1000 Blks.

~~14583~~ 20.49659 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49659

CERTIFICATE OF DEATH. X 74

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Ross G. Shepherd

(a) RESIDENCE. No. 91 Queen St. St. Catherines ST., Ontario Canada WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21st 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Charles Shepherd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Jennie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) J. H. Hospital Records

15 Filed JAN 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Jan 6, 1921, that I last saw h.. alive on Jan 6, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Shock following operative removal of tumor of pineal body.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebellar tumor.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? St Catherines Ont Canada.

Did an operation precede death? Yes Date of Dec 28 1920

Was there an autopsy? Yes

What test confirmed diagnosis? Tumor removed & pathologically examined

(Signed) J. H. Thomson, M. D.

, 19 (Address) Johns Hopkins Hosp. Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Catherines Ontario Canada	Jany 8 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Fayette St.

TION IS VERY IMPORTANT

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B49660 — 1921 B49660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E. 23rd St.) 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jane Waltman

(Residence in Baltimore: No. 505 E. 23rd St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 15 (Day), 1839 (Year)

7-AGE, 81 yrs. 7 mos. 22 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Cecil Co. Md.

PARENTS.

10-NAME OF FATHER, Michael Harman

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Nancy Buskins

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Daisy Waltzman

(Address) 505 E. 23rd st

15-

Filed ..... 1921, 191.....

Robert P. Harrison, Registrar.

JAN 8 - 1921

Burial Permit Clerk

Dr Jack Bradley

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Jan 6 1921, that I saw h.. alive on Jan 6 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion & Coma

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Ally A Gage M. D.

1/6/21, 191... (Address) 786 N Bdway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 8 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Jan. 8..., 1921

20-UNDERTAKER Chas G Black

ADDRESS 742 N Fort ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.49661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49661

CERTIFICATE OF DEATH.

110

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Marion Jones

(Residence in Baltimore: No. 818 W. 40th St. St.; 37 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 14, 1883.
(Month) (Day) (Year)

7-AGE, 37 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Registered Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)..... 048

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Thomas B. Jones.

11-BIRTHPLACE OF FATHER (State or Country). Fredericksburg

12-MAIDEN NAME OF MOTHER Marion V. Dushane

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas B. Jones.

(Address) 818 W. 40th St.

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

JAN 8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1921, to Jan. 7, 1921, that I saw her alive on Jan. 7, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Acute peritonitis,

(Duration).....yrs.....mos.....1.....ds.

CONTRIBUTORY (Secondary) Fecal fistula & Operation

(Duration).....yrs.....3.....mos.....ds.

(Signed) Frank J. Wartheimer M. D.

Jan. 7, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 2 ds. In the State 37 yrs.....mos.....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 818 W. 40th St.

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Jan 8., 1921

20-UNDERTAKER Henry H. Perkins & Son Inc. ADDRESS Orchard & McCulloh Sts

...—6-9-19—H. P. Co.—1000 Eks.

D.49662 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49662

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth Dooley

(a) RESIDENCE. NO. 2407 Barclay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 006

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Mrs D Craig

(Address) 2407 Barclay St

JAN 8-1921 Robert P. Harrison,

Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1920, to Jan. 7, 1921, that I last saw her alive on Jan. 7, 1921, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1hr ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma O. Ridgely, M. D.

1/7, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 10 1921

20 UNDERTAKER ADDRESS

Martin Fahey & Sons 1827 W Monty

pec.—6-9-19—H. P. Co.—1000 Bks.

20.49663

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.49663

CERTIFICATE OF DEATH.

91-151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Asylum ST. 14 WARD)

2-FULL NAME Mary Elizabeth Sheehy

(a) RESIDENCE. NO. 1401 Dunkirk St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	#	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Sheehy

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Reynard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant St. Vincent Asylum
(Address) 1401 Dunkirk St

15 Filed ....., 19 Registrar

N 8 1921 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Jany 3, 1921, that I last saw her alive on Jany 2, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Premature Birth

Weight 4 lbs (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Elias Helander, M. D.

(Address) 1501 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 8 1921

20 UNDERTAKER Martin Fahey Jr & Sons ADDRESS 1827 W North Ave

TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49664 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1249 Haubert St. ST.; 24 WARD) REGISTERED NO. C 152

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Mary Regena Peterson

(Residence in Baltimore: No. 1249 Haubert St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) New born

6-DATE OF BIRTH, January 7, 1921. (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 0 hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: New Born
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Wm Peterson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Elizabeth Spencer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Wm Peterson

(Address) 1249 Haubert St

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

JAN 8-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 7 1921, to Jan. 7 1921, that I saw her alive on Jan. 7 1921, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Slow Labor Dry Labor

(Duration) 30 Hrs mos. ds.

(Signed) E. Mich Nowak M. D.

Jan. 7., 1921. (Address) 26 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Jan 8, 1921

20-UNDERTAKER John F Denny

ADDRESS 715 1/2 E. Pratt St

pec.—6-9-19—H. P. Co.—1000 Bks.

20.49665 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49665

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Breaver

(a) RESIDENCE. No. 515 Greenmeadow ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC 31-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Brawner

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Bessie Katz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant
(Address)

15 Filed JAN 8-1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1920, to Dec 31, 1920, that I last saw him alive on Dec 31, 1920, and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morris Rene, M. D.

1-1, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health,	ADDRESS JAN 8 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49666

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Massey

(a) RESIDENCE. NO. 405 N. Durham St. WARD. Aberdeen Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred (yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4 1898

7 AGE: Years 22; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farm hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Hay. Ha. Tarsney Aberdeen Co Md

15 Filed JAN 8 - 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Jan 5, 1921, that I last saw h[e] alive on Jan 5, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Mesenteral abscess

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 27-1920

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. W. Pentecost, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md — DATE OF BURIAL: Jan 9 1921

20 UNDERTAKER: Wm J. Tickner & Sons — ADDRESS: N & J. ave

It is very important that

Spec.—8-24-14—M. & T.—2000 Bks.

0.49667 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49667

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 948 W. Saratoga ST.; 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Williams

(Residence in Baltimore: No. 948 West Saratoga St.; 22 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, September (Month) 10 (Day), 1896 (Year)

7-AGE, 24 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Northumberland Co Va

PARENTS.

10-NAME OF FATHER, Allen Williams

11-BIRTHPLACE OF FATHER (State or Country) Essex County Co

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), Northumberland Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Williams

(Address) 948 West Saratoga St

15- Filed JAN 8 1921, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 7th (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from January 2nd 1921, to January 7 1921, that I saw h[illegible] alive on Jan 6 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

[illegible]

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Jan 7 1921. (Address) 1369 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. North Thunderland Co

DATE OF BURIAL. Jan 9, 1921

20-UNDERTAKER George H. Holland

ADDRESS 1631 Lemmon Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

0.49668 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.49668

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Ridgely ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmira Eldridge

(Residence in Baltimore: No. 912 Ridgely St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	W	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1852 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Joseph Holland

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER, Adeline Brown

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe Holland

(Address) 912 Ridgely St

15- Robert P. Harrison,
(Date) AUG 8 1921, 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1921, to June 7 1921, that I saw h.. alive on June 6 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Nephritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Edema of Lungs & Uremia

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. Shaw M. D.

(Address) 6 E Lexington St.

June 8, 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	June 10, 1921
20-UNDERTAKER	ADDRESS
F. J. Lakey & Sons	1318 Eutaw St

spec.—6-9-19—H. P. Co.—1000 Bks.

0.49669 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49669

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 W. Balto. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Martha Webb

(a) RESIDENCE. NO. 1602 W. Balto. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Webb.

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Jane Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant (Address) Robt J. Webb Sr. 1602 W. Balto. St.

15 Filed JAN 8-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to Jan 7, 1921, that I last saw her alive on Jan 7, 1921, and that death occurred, on the date stated above, at 11, 30 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia ooo

(duration) 6 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Hilles Hemming M. D.

1/8, 1921 (Address) 7000 Holland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan 10, 1921
20 UNDERTAKER	ADDRESS
George J. Smith	2000 W Fayette St.

TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49670 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49670

CERTIFICATE OF DEATH. X 18 91-089

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hosp ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leslie Blake

(Residence in Baltimore: No. 1823 Pork Ave St.; ..... yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 5 (Day), 1919 (Year)

7-AGE, 1 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Not Employed
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Mr. Barrett

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Helen Blake

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jos. A. Hutton

(Address) N.H. Hospital

15-

Filed ....., 191.....

JAN 8-1921 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to Jan 8, 1921, that I saw him alive on Jan. 7, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) .....yrs. 12 mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. J. Tenglers M. D.

1/8/, 1921 (Address) 2002 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 13 ds. In the State .....yrs. 3 mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1823 Pork Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Jan 8, 1921
20-UNDERTAKER	ADDRESS
Geo. J. Smith	2 E Pratt St

No other infection than acute bronchitis.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49671 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49671

CERTIFICATE OF DEATH. X104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Asylum ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Cates

(a) RESIDENCE. NO. St Vincent asylum ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? 1 yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Isaac Cates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant S.W. Matthews
(Address) 1401 Druid St.

15 Filed 1921 [Robert P. Harrison, Registrar
Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 2, 1921, to Jany 6, 1921, that I last saw him alive on Jany 5, 1921, and that death occurred, on the date stated above, at 7 Am m.

The CAUSE OF DEATH* was as follows:

Aller Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Edumatism

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Heldrick M. D.

(Address) 1502 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity	Jan 8- 1921
20 UNDERTAKER William Cook	ADDRESS 502 S North Ave

FILL IN very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49672

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Seymour.

(a) RESIDENCE. NO. 4604 York Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Rose Seymour.

6 DATE OF BIRTH (month, day, and year) October 7-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Business

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbott Co

PARENTS

10 NAME OF FATHER Robert Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Malinda Starker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant. (Address) Rose Seymour 4604 York Road

15 Filed ....., 19 ..... Robert F. Garrison, Registrar

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-8 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1920, to Jan-8, 1921, that I last saw him alive on Jan 8, 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of Dec 16.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard B McElwain, M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan. 11 1921

20 UNDERTAKER William Cook — ADDRESS 502 S. Hall Ave

spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20.49673

20.49673

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 130 William ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H Smith Jr

(a) RESIDENCE. NO. 130 William ST., 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, 3 hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Edith Woodward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Smith

(Address) 130 William St

15 Filed JAN 8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to Jan 8, 1921, that I last saw him alive on Jan 8, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Congenital valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mule Stiffler, M. D.

1/8, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt J. E. Cem Assn	June 1921
20 UNDERTAKER	ADDRESS
Balto Cemetery	1400 Eutaw St

Spec. 6-9-19 H. P. Co. 1000 Blks.

49674

HEALTH DEPARTMENT—CITY OF BALTIMORE

49674

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2322 Stockton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassie Carter

(a) RESIDENCE. No. 2322 Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 071

(b) General nature of industry, business, or establishment in which employed (or employer) Preparing food.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandy Springs Montgomery Co. Md

PARENTS

10 NAME OF FATHER Thomas Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sandy Springs Montgomery Co. Md

12 MAIDEN NAME OF MOTHER Cassandra Pumphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sandy Springs Montgomery Co.

14 Informant Samuel J. Hemsley

(Address) 578 N. Biddle St.

15 Filed JAN 9-1921 ROBERT E. CRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Jan 5th, 1921, that I last saw her alive on Jan 2, 1921, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos. 25 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis. Cardiac Enlargement (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Typical

(Signed) Wm. H. Wright, M. D.

1921 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1/8/21

20 UNDERTAKER Samuel J Hemsley

ADDRESS 578 N Biddle

pec.—6-9-19—H. P. Co.—1000 Bks.

49675 HEALTH DEPARTMENT—CITY OF BALTIMORE 49675

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McGill

(a) RESIDENCE. No. 818 E. pratt st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McGill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McHenry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address) M. T. H.

15 Filed JAN 9-1921 Burial Permit Clerk

DOES NOT REQUIRE REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1921, to Jan. 8, 1921, that I last saw him alive on Jan. 7, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

1-8-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cemetery	January 8th 1921
20 UNDERTAKER	ADDRESS
Mr & Mrs N. S Finch	1835 E. Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

49676

HEALTH DEPARTMENT—CITY OF BALTIMORE

49676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 E Randall ST., 24 WARD)

REGISTERED NO. 152

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Eisel

(a) RESIDENCE. NO. 601 E Randall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 4 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George F Eisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Clinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George F Eisel

(Address) 601 E Randall

15 Filed JAN 9-1921 ROBERT I KRAUTER Registrar

Burial Permit Given

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 8, 1921, that I last saw her alive on Jan 7, 1921, and that death occurred, on the date stated above, at 3 55 a m.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull during instrumental delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Griffith, M. D.

1/8. 1921 (Address) 1319 Light,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 8 1921

20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

49677 HEALTH DEPARTMENT—CITY OF BALTIMORE 49677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD) 64

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lee Marshall -

(Residence in Baltimore: No. Room was shopping at Jones Hotel St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Don't Know

6-DATE OF BIRTH, Sept 23, 1866 (Month) (Day) (Year)

7-AGE, 54 yrs. 3 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... B&O R.R. foreman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 073

9-BIRTHPLACE, (State or Country), Engle W. Va.

PARENTS.

10-NAME OF FATHER, Jas M. Marshall

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Mangle Engle

13-BIRTHPLACE OF MOTHER (State or Country), Engle W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Frank Trip

(Address) Kearneysville W. Va.

15- JAN 9 - 1921 ROBERT B KRAUTER

Filed....., 191.... Burial Permit Clerk

Registrar.

important. See instructions on back of Certificate

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours (Duration)..yrs..mos..ds.

CONTRIBUTORY (Secondary) Don't know of any

(Duration)..yrs..mos..ds.

(Signed) W. K. Foreman M. D. (Coroner.)

1-8, 1921 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Kearneysville W Va

19-PLACE OF BURIAL OR REMOVAL, Kearneysville W. Va

DATE OF BURIAL, Jan 9, 1921

20-UNDERTAKER Jos B Cook

ADDRESS 1032 N Balto St

D49678 HEALTH DEPARTMENT—CITY OF BALTIMORE D44678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. ST.: 22 WARD) 170 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert C. Jackson. (C)

(Residence in Baltimore: No. 828 S. Sharp Street. 11 ------- 6. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, December 30th 1909, 1 (Month) (Day) (Year)

7-AGE, 11 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 800
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Levi C. Jackson. (C).

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Minnie E. Maddox. (C).

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levi C. Jackson. (C). (father)

(Address) 828 S. Sharp Street.

15-JAN 9 - 1921 ROBERT B KRAUTER
Filed....., 191.... Burial Permit Clerk
Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5th, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest & autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage and destruction of Brain tissue due to pistol shot wound in the head. Accidental Death.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Leonhardt M. D.
(Coroner.)
Jan 8th, 21; 191.. (Address) 211 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, M. C. Cemetery — DATE OF BURIAL, 1/9/21

20-UNDERTAKER J. H. Toadvine — ADDRESS 1732 W. Mile

Dec.—6-9-19—H. P. Co.—1000 Bks.

649679 HEALTH DEPARTMENT—CITY OF BALTIMORE 649679

CERTIFICATE OF DEATH.

8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2410 E North ave ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M Ashton

(a) RESIDENCE. No. 2410 E North ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State) Life

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1919

7 AGE: Years 1 Months 2 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John H Ashton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Edna M Fasbender

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant: John H Ashton
(Address) 2410 E North ave

15 Filed JAN 9 - 1921 ROBERT P LAMBERT Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 8, 1921, that I last saw h.w alive on Jan 8, 1921 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping cough.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frisch, M. D.

(Address) 1823 N. West st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 1/9/21 19

20 UNDERTAKER: William Cook 502 E Balt av — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

049680 HEALTH DEPARTMENT—CITY OF BALTIMORE 049680

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Bruce St. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel G. Pletzer

(a) RESIDENCE. NO. 706 Bruce St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Pletzer

6 DATE OF BIRTH (month, day, and year) July 11-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Battery man

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Pletzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know.

12 MAIDEN NAME OF MOTHER Eliza Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mary E. Pletzer

(Address) 706 N Bruce St.

15 DATE RECEIVED JAN 9-1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6- 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1920, to Jan 6th, 1921, that I last saw h.. alive on Jan 6th, 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

, 19 (Address) 1132 Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan 10- 1921.
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

TION is very important. See instruction

Russell - Milton Ave & Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L049681 HEALTH DEPARTMENT—CITY OF BALTIMORE L049681

CERTIFICATE OF DEATH. 25-28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 503 Frederick St. 25 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna H. Baughman

(a) RESIDENCE. No. 503 Frederick St. Boro'lyn WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Baughman

6 DATE OF BIRTH (month, day, and year) Feb 19-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Raymond E Baughman

(Address) 503 Frederick St

15 Filed JAN 9-1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1921, to Dec. 8, 1921, that I last saw him alive on Dec. 7th, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Asthma aww

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William D. Jarrett, M. D.

Jan 8, 1921 (Address) 816 - Penna Ave - City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Jan 11 1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

Rum

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49682 D49682

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N Gay St ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. Rum

(a) RESIDENCE. NO. 508 N Gay St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Rum

6 DATE OF BIRTH (month, day, and year) June 22. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 109

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert E Rum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Robert Rum

(Address) 508 N Gay St

15 Filed JAN 9 - 1921 19 ROBERT I. LEVERTON Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1921 to Jan 7 1921

that I last saw h.. alive on Jan 4 1921

and that death occurred, on the date stated above, at 4-40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? X Microscope

(Signed) D. Lee Magruder M. D.

(Address) 1206 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 10 1921
20 UNDERTAKER	ADDRESS
Wm Cook.	N & G. Ave

THIS IS VERY IMPORTANT. USE TYPEWRITER.

Spec.—8-24-14—M. & T.—2000 Bks.

649683

HEALTH DEPARTMENT—CITY OF BALTIMORE

649683

150-010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N. Broadway ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Strauss-

(Residence in Baltimore: No. 923 N Broadway- St.; 1 yrs., 2 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, November 5, 1919.
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Louis Strauss

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Rose Tolchinsky

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Strauss

(Address) 923 N. Broadway

15-JAN 9-1921 ROBERT J KRAUTER

Filed....., 191..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~November~~ January 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1920, to Jan. 6, 1921, that I saw her alive on Jan. 6, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

.....

Pneumonia

Bronchitis

..... (Duration) 6 yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Congenital Heart

..... (Duration) 1 yrs. 7 mos. 0 ds.

(Signed) J. M. Knox Jr. M. D.

Jan 9, 1921. (Address) 1117 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, Jan. 9, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Baltimore

Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

#49684

#49684

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Leslie Mendel

(a) RESIDENCE. NO. 9 N Front ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Mendel

6 DATE OF BIRTH (month, day, and year) June 5. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Romania

PARENTS

10 NAME OF FATHER Samuel Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Romania

12 MAIDEN NAME OF MOTHER Antonow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Romania

14 Informant (Address) J Lewis 1411 E Balto St

15 Filed JAN 9 - 1921 16 ROBERT I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to June 8, 1921, that I last saw h.. alive on June 8, 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 31 1913

Was there an autopsy? No

What test confirmed diagnosis? Lab Exam

(Signed) Edward A Kaufman, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew

DATE OF BURIAL 6/9 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt

TION is very important. See

Spec. 6-9-19 H. P. Co.—1000 Blks.

649685 HEALTH DEPARTMENT—CITY OF BALTIMORE 649685

CERTIFICATE OF DEATH. 8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1345 Ramsey ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Gugliett

(a) RESIDENCE. NO. 1345 Ramsey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Gugliett

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Beal

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md
(State or country)

14 Informant Mrs. Mary [redacted]gliett
(Address) 1345 Ramsey st

15 Filed JAN 9-1921 ROBERT J. CHAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to Jan 8, 1921, that I last saw h— alive on Jan 8, 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) old Pertusis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Vaccaro, M. D.

8, 1921 (Address) 1345 Ramsey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Jan 9 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca St

THIS IS NOT A BURIAL PERMIT

Spec.—6-9-19—H. P. Co.—1000 Bks.

049686 HEALTH DEPARTMENT—CITY OF BALTIMORE 049686

CERTIFICATE OF DEATH. 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Park ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarett Brigha

(a) RESIDENCE. No. 1203 Park ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — DOM

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Briggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Beatrice Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U S

14 Informant Beatrice Briggs
(Address) 1203 Park Ave

15 Filed JAN 9 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Janu 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1920, to Janu 7, 1921, that I last saw h e alive on Dec. 31, 1920, and that death occurred, on the date stated above, at 12.30 C. m.

The CAUSE OF DEATH* was as follows:

DOM

Bronchio-Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Pelletreau M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Janu 10th 1920
20 UNDERTAKER	ADDRESS
Felix B Pye	102 E Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

049687 HEALTH DEPARTMENT—CITY OF BALTIMORE 049687

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Cor Forrest & Chase ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister M. Genevieve Newman

(Residence in Baltimore: No. St. Frances Convent 50 yrs St.; 40 yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov (Month) 15 (Day), 1850 (Year)

7-AGE, 70 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sister
(b) General nature of industry, business, or establishment in which employed (or employer): Teacher

9-BIRTHPLACE, (State or Country), New Orleans La.

PARENTS.

10-NAME OF FATHER, Nelson Kooman

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Irene Newman

13-BIRTHPLACE OF MOTHER (State or Country), New Orleans

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Mary Frances Fiddes

(Address) St. Frances Convent St. & Forrest Pl.

15-

Filed JAN 9-1921, 191.... ROBERT I. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 191.., to Jan 7 1921, that I saw her alive on Jan 7 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Mary F Vaughan M. D.

Jan 8, 1921. (Address) 10 28 E Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery. DATE OF BURIAL, Jan 10th, 1921

20-UNDERTAKER Felix J Pye ADDRESS 102 E Mulberry

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wubbold

HEALTH DEPARTMENT—CITY OF BALTIMORE

049688 049688

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3421 Frederick Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wubbold

(a) RESIDENCE. NO. 3421 Frederick ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Wubbold

6 DATE OF BIRTH (month, day, and year) Oct 5-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Wubbold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine McCoskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Augusta Wubbold 3421 Frederick Ave.

15 Filed JAN 9 - 1921

[illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Jan 7, 1921, that I last saw h[illegible] alive on Jan 7, 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) 3 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A. Knell, M. D.

1/7, 1921 (Address) 4207 Fredrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan. 9. 1921
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave.

TION is very important. See

D49689 HEALTH DEPARTMENT—CITY OF BALTIMORE D49689

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Ch Home E. Infirm St. 1 WARD) REGISTERED No. C.....

2-FULL NAME Mildred D. Holland

(Residence in Baltimore: No. 3127 Fait Ave. St.: life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug 24, 1900
(Month) (Day) (Year)

7-AGE, 20 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Sawyer.

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Holland

(Address) 3127 Fait Ave.

15- Filed JAN 9-1921, 191.... ROBERT B KRAUTER Registrar
Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Hg. Cl. Poisoning

(Duration) yrs. mos. 15 ds.

(Signed) J. C. B. Riddy M. D.
(Coroner.)

1/9/21, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ft Dixet Cem.	Jan 13, 1921
20-UNDERTAKER Peter F. Fields.	ADDRESS 1200 N. Conkling St.

L049690

Spec.—6-9-19—H. P. Co.—1000 Bks.

L049690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Cottage Ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Ray

(a) RESIDENCE. No. 3913 Cottage Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Howard A. Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Morganwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Howard A. Ray

(Address) 3913 Cottage Ave

15 Filed JAN 9 - 1921, 19 ... Registrar

TION is very important. See instruc-

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1920, to Jan 7, 1921, that I last saw her alive on Jan 6, 1921, and that death occurred, on the date stated above, at 8 20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and abscess of lung

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Unresolved bronchio-pneumonia (Influenzal) (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X ray -

(Signed) J. Evan Dreiwend M. D.

1/8 1921 (Address) 846 W 36 St 86.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan. 10 1921

20 UNDERTAKER Horace Burgee & Son ADDRESS 363 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

099691

HEALTH DEPARTMENT—CITY OF BALTIMORE

099691

CERTIFICATE OF DEATH.

REGISTERED NO. 39

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Smith

(a) RESIDENCE. No. 1630 N. Milton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? fifty yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinsmith 88

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER William J. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records,

(Address) New City Hospital.

15 Filed JAN 9-1921 ROBERT I KRAUTER Registrar

Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 21, 1920, to January 6, 1921, that I last saw him alive on January 6, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face tongue (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? exam.

(Signed) J. A. Holdeen, M. D.

1/7/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 10th 1921

20 UNDERTAKER Mrs. C. Miller ADDRESS 2334 Jefferson St

L49692 HEALTH DEPARTMENT—CITY OF BALTIMORE L49692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 510 N Medeira ST.: 7 WARD)

REGISTERED No. C 79

2-FULL NAME James F Hennick

(Residence in Baltimore: No. 510 N Medeira St.; yrs. 7 mos. Life ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, August 20, 1853
(Month) (Day) (Year)

7-AGE, 68 yrs. 5 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward R Hennick

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sally Austin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Hennick

(Address) 510 N Medeira

15- Filed JAN 9-1921, 191.... ROBERT B KRAUTER Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanosis Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

1-7, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Jan 10th 1921

20-UNDERTAKER Wm C Miller

ADDRESS 2834 Jefferson St

CAUSE of death must be stated so that it will be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1649693 1649693

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mersity Hospital ST.: 19 WARD)
2-FULL NAME Anna Druglof
(Residence in Baltimore: No. 1300 McHenry St

REGISTERED NO. C 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: (yrs., 7 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married
6-DATE OF BIRTH, Don't Know, 1
(Month) (Day) (Year)
7-AGE, 28 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Russia

PARENTS.
10-NAME OF FATHER, Vincent Ramanauskas
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER Cathern Karsokas
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. Slaboda
(Address) 1311 Hanover St.

15- Filed JAN 9-1921, 191 ROBERT J. SLAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry.~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~or inquiry.~~) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomatic Peritonitis caused by bowel wound in abdomen
(Duration) yrs. 1 mos. 3 ds.
CONTRIBUTORY (Secondary) John Druglof
(Duration) yrs. mos. ds.
(Signed) M. K. Gorsuch M. D.
(Coroner.)
1-9, 1921. (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislowas
DATE OF BURIAL, January 10, 1921
20-UNDERTAKER John Grabliauskas
ADDRESS 425 S. Paca St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49694 HEALTH DEPARTMENT—CITY OF BALTIMORE D49694

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Guilford Ave ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Hossbach

(a) RESIDENCE. No. 2225 Guilford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno E Hossbach

6 DATE OF BIRTH (month, day, and year) June 4-1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59 —	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Cincinnati (State or country) Ohio

PARENTS

10 NAME OF FATHER Jos. F Scherle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Brand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jno E Hossbach (Address) 2225 Guilford

15 Filed JAN 9-1921 19 ROBERT I KRAUTER Registrar Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Jany 7th, 1921, to Jany 7th, 1921, that I last saw h[illegible] alive on July 17th, 1920, and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W A Fair M. D.

1921 (Address) 1 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	1/10 1920
20 UNDERTAKER	ADDRESS
C. Fred McCully	130 E. Fay

Spec.—6-9-19—H. P. Co.—1000 Bks.

049695 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 049695

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1456 W. Lorey ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Dorn

(a) RESIDENCE. NO. 1456 W Leorey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 06 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marguerite Dorn.

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ex. Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer Pensioner.

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Abraham Dorn

11 BIRTHPLACE OF FATHER (city or town) Kent Co (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) Kent Co (State or country) Md.

14 Informant Marguerite Dorn (Address) 1456 W Leorey

15 JAN 9-1921 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1920, to Jan 6, 1921, that I last saw h— alive on Jan 6, 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Hemiplegia) (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Aged, Arteno Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1456 W Leorey

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Jan 7. 1921 (Address) 1209 Prestman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Jan 10 1921
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

TION is very important. Be sure

Spec.—8-24-14—M. & T.—2000 Bls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16496 16496 16496

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 22 50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Siegel

(Residence in Baltimore: No. 714 Hanover St St.; 18 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1885 (Year)

7-AGE, 36 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Tovchen Siegel

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mahrowsi

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P Berman

(Address) 14 N Gay St

Filed JAN 9-1921 191. ROBERT F KRAUTER BURIAL PERMIT CLERK.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1 1921, to January 8 1921, that I saw him alive on January 1 1921, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ... yrs. 7 mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) 9 yrs. ... mos. ... ds.

(Signed) ..... M. D.

1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 10 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 714 Hanover St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Rd

DATE OF BURIAL, Jan. 9, 1921.

20-UNDERTAKER Wm Jenkinson

ADDRESS 1127 E Baltimore St

49697 HEALTH DEPARTMENT—CITY OF BALTIMORE 49697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 18 W. Hamilton ST. 11 WARD) 79 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip P. Dandridge

(Residence in Baltimore: No. 18 W Hamilton St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Man	white	Single

6-DATE OF BIRTH, Dec 7, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, P. P. Dandridge

11-BIRTHPLACE OF FATHER (State or Country), W Va.

12-MAIDEN NAME OF MOTHER C. Coldsborough

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs P. Dandridge

(Address) 18 W Hamilton

15- Filed JAN 10 1921, 191... ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration 1 day

CONTRIBUTORY (Secondary) Senile Decay

Duration yrs. mos. ds.

(Signed) M. D. (Coroner.)

Jan 9, 1921 (Address) 1029 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Manchester Va	Jan 10, 19..
20-UNDERTAKER Henry W. Perkins	ADDRESS 1216 Collins Ave

Observe instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49698 HEALTH DEPARTMENT—CITY OF BALTIMORE D49698

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3771 Caroline St. ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M Hudson

(a) RESIDENCE. No. 3771 Caroline ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Hudson

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Renard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Penning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles W. Hudson

(Address) 3771 Caroline St

15 JAN 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Jan 8, 1921, that I last saw h[illegible] alive on Jan 7, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Mediastinal Tumor
Carcinoma

(duration) chr 4 mo. yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) H. W. Jacobs, M. D.

(Address) 2 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 10 1921
20 UNDERTAKER George J. Smith & Sons	ADDRESS 1000 W. Lexington St

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49.699 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49699

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 W. Baltimore ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Willis Harding

(a) RESIDENCE. NO. 1828 W. Baltimore ST., 19th WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 72 yrs. 9 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A. Harding

6 DATE OF BIRTH (month, day, and year) April 9 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ships Brokerage Business

(c) Name of employer

9 BIRTHPLACE (city or town) South Dennis

(State or country) Massachusetts

PARENTS

10 NAME OF FATHER Peleg B Harding

11 BIRTHPLACE OF FATHER (city or town) South Dennis

(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Betsy Hall

13 BIRTHPLACE OF MOTHER (city or town) Cape Cod

(State or country) Massachusetts

14 Informant Miss Lula V. Harding (daughter)

(Address) 1828 W. Baltimore St

15. JAN 10 1921 Registrar

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1920, to Jan 6th, 1921, that I last saw him alive on Jan 6, 1921, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) John Heath, M. D.

1/6/21, 19 (Address) 1248 W. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 10 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049700 HEALTH DEPARTMENT—CITY OF BALTIMORE 049700

CERTIFICATE OF DEATH. 37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospitals, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Crew

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) May 30 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records City Hospitals, Bay View

15 FILED JAN 10 1921 ROBERT E. LEAUTER Registrar

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1920, to Jan. 7, 1921, that I last saw h.. alive on Jan. 7, 1921, and that death occurred, on the date stated above, at 1 0 P. m.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) P. H. Herrman M. D.

Jan 9, 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 10 1921
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Rhodes

L49701

HEALTH DEPARTMENT—CITY OF BALTIMORE

L49701

CERTIFICATE OF DEATH.

4H

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 N Wolf ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L Rhodes

(Residence in Baltimore: No. 1508 North Wolf St. Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, April 7, 1863.
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 062

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William T Rhodes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emeline Roby

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie M Rhodes

(Address) 1528 N Wolfe St

15-
JAN 10 1921
Filed ....., 191.....
ROBERT E KRAUTER
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to January 9 1921, that I saw him alive on January 9 1921, and that death occurred, on the date stated above, at 230 a m.

The CAUSE OF DEATH* was as follows:

Cancer of the Right Diaphragm

(Duration) about one yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H young Westbrook M. D.

Jan 12, 1921 (Address) 11 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem't | DATE OF BURIAL, Jan 12, 191...

20-UNDERTAKER Wm Cook & Son | ADDRESS Balto

D802 Dr Stemmerwap

D49702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D49702

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3315 Walbrook Av St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ehrhart

(Residence in Baltimore: No. 3315 Walbrook Av St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Wdw

6-DATE OF BIRTH, Sept 21, 1859
(Month) (Day) (Year)

7-AGE, 61 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tower 100
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Phila. Pa.

PARENTS.

10-NAME OF FATHER, George Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary A Shantucher

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edward A Leach

(Address) 266 Roberts St

15- Filed JAN 10 1921 191.... ROBERT J KRAUTER Burial Permit Clerk
Registrar.

Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fracture of skull (10 minutes)
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) accident (fell down cellar steps)
(Duration) yrs. mos. ds.
(Signed) J. J. Hennessy M. D.
(Coroner)
Jan. 9, 1921 (Address) 2802 Greenmount Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park
DATE OF BURIAL, Jan 12 1920

20-UNDERTAKER Wm Cook
ADDRESS 702 E Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 049703

049703

151

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2105 Huntingdon St. 12 WARD)

2-FULL NAME John Lytle

(a) RESIDENCE. NO. 2105 Huntingdon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 - 1921

7 AGE — Years — Months — Days. If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ballard Ind

PARENTS

10 NAME OF FATHER John Lytle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Leticiam Mengel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Lytle (Address) 2105 Huntingdon

15 Filed JAN 10 1921 ROBERT P. LATIMER Registrar

Burial Permit Clerk

TION is very important. See instructions on cover.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to Jan 9, 1921, that I last saw h.. alive on Jan 9, 1921, and that death occurred, on the date stated above, at 9 am.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. H. Pearce, M. D.

, 19 (Address) 2105 Huntingdon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL 1/10 1921

20 UNDERTAKER Wm. Cook — ADDRESS 501 E Natl

D49704 HEALTH DEPARTMENT—CITY OF BALTIMORE D49704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3927 Eastern ave ST. 26 WARD)

REGISTERED No. C 120

2-FULL NAME John G. Hamel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 702 S. 5th st. St.; yrs., 57 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Widowed

6-DATE OF BIRTH, ... Feb. ....., 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John G. Hamel

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Hamel

(Address) 3525 Clairmont Ave

15- Filed JAN 10 1921, 191.... ROBERT B KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Jan 7 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Medical Autopsy ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Autopsy ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Chronic Nephritis .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Cardiac Asthma .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

1/9 ....., 1921 (Address) 1004 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Jan. 10, 1921
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Sienkiewicz

D 49705

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 49705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 513 S Patterson Park Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ryta Sienkiewicz

(a) RESIDENCE. No. 513 S Patterson Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 10 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Sienkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Kutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Sienkiewicz (Address) 513 S Patterson Park Ave

15 Filed JAN 10 1921 ROBERT P. BEASTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 19 21, to Jan 9th 19 21,

that I last saw h er alive on Jan 9th 19 ...,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Congestive Weakness

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Grandma

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

..... 19 2/ (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Jan 10 1921
20 UNDERTAKER	ADDRESS
Jas R Ateber	1803 Bank

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49706

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 N. Lombard ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam M. Schelsky

(a) RESIDENCE. No. 840 N. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or, ~~WIFE~~ of) Lillian A. Schelsky.

6 DATE OF BIRTH (month, day, and year) Dec. 24 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Examiner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs Lillian A. Schelsky

(Address) 840 N. Lombard St

15 Filed JAN 10 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

THIS is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from January 14 1920, to Jan. 8, 1921, that I last saw him alive on Jan 8 1921, and that death occurred, on the date stated above, at 3.35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Test

(Signed) H. J. Carrick M. D.

Jan 9. 1921 (Address) 412 N. Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 13 1921
20 UNDERTAKER Henry Hook Son	ADDRESS 1301 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49707

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D49707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Durham ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Bevens

(a) RESIDENCE. No. 5 N Durham St., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lester Bevens

6 DATE OF BIRTH (month, day, and year) April 11- 879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Carrie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elizabeth Bevens
(Address) 5 N. Durham St.

15 Filed JAN 10 1921 ROBERT E. LEACH Registrar Burial Permit Office

THIS is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 6, 1921, that I last saw h... alive on Jan 6- 1921, and that death occurred, on the date stated above, at 5.10 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abscess of Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A E Long, M. D.

1-8, 1921 (Address) 901 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville	Jan 8 1921

20 UNDERTAKER Wendell & Lippold ADDRESS 37 Hamilton

Spec.—6-9-19—H. P. Co.—1000 Bks.

449708

HEALTH DEPARTMENT—CITY OF BALTIMORE

449708

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Myrtle Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hicks

(a) RESIDENCE. NO. 414 Myrtle Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) Todd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joshua Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant Joshua Hicks
(Address) 414 Myrtle Ave

15 Filed JAN 10 1921 ROBERT B. LEGATES Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to Jany 8th 1921, that I last saw him alive on Jany 7th, 1921, and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) Yrs. Mos. Ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion

(duration) Yrs. Mos. Ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Fowler M. D.

1921 (Address) 767 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 10 1921
20 UNDERTAKER David Forbes	ADDRESS 916 Eutaw

THIS is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49709

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D49709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Pinkney

(a) RESIDENCE. No. 412 N. Gilmor St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address) New City Hospital.

15 Filed JAN 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit 07578

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1921

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1921, to January 7, 1921, that I last saw her alive on January 7, 1921, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene both legs & back at spaces). Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia & Bronchopneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam-

(Signed) J. A. Holden, M. D.

1/7/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 10 1920
20 UNDERTAKER Daniel Taylor's	ADDRESS 916 Pa ave

TION IS very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49710 HEALTH DEPARTMENT—CITY OF BALTIMORE 151 L49710

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1067 Myrtle Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE. NO. 1067 Myrtle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Brown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Shelton

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lillian Brown
(Address) 1067 Myrtle ave

15 Filed JAN 10 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to Jan 8, 1921, that I last saw h... alive on Jan 8, 1921, and that death occurred, on the date stated above, at 10 5A p.m.

The CAUSE OF DEATH* was as follows:

1 Miscarriage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Brown, M. D.

1/8, 1921 (Address) 1837 Pa ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Orlando Brown	Jan 10 1920
20 UNDERTAKER Denis Taylor	ADDRESS 916 Pa ave

TION IS very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

64 L 49711

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 49711

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Clarkson ST. 23 WARD)

2-FULL NAME Mary E Bokhultz

(a) RESIDENCE. NO. 1534 Clarkson ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of the late John Bokhultz

6 DATE OF BIRTH (month, day, and year) July 16 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Truon Sager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nancy Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Black (Address) 1534 Clarkson St

15 Filed JAN 10 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Jan 7, 1921.

That I last saw h[illegible] alive on Jan 7, 1921.

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2 (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Infirmities

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R E Campbell, M. D.

1/8, 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Jan 10 1921
20 UNDERTAKER	ADDRESS
Wm F Evans & Sons	1428 Linden Ave

TION is very important. See instructions on back

Spec. 6-9-19 H. P. Co.—1000 Blks.

L49712 HEALTH DEPARTMENT—CITY OF BALTIMORE L49712

CERTIFICATE OF DEATH. +9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital (WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ennis Batton.

(a) RESIDENCE. NO. 802 S. Hanover ST., WARD. Annapolis Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 8-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) annapolis md.

PARENTS

10 NAME OF FATHER Ennis M. Batton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Green Co. Va.

12 MAIDEN NAME OF MOTHER Mamie Figg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) annapolis Md.

14 Informant E. M. Batton.
(Address) 802 S Hanover St.

15 FILED JAN 10 1921 [illegible] Registrar
Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan 9, 1921, that I last saw him alive on Jan 8, 1921, and that death occurred, on the date stated above, at 1:00 a m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Diphtheria, Tonsillar

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures.

(Signed) B MacGowan, M. D.

Jan 10 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	1/10 1921
20 UNDERTAKER	ADDRESS
[illegible]	618 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

H49713 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049713

CERTIFICATE OF DEATH. 105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Violi

(a) RESIDENCE. NO. 2317 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 14-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ✓

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jerome Violi

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen V. Mahoney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Jerome Violi (Address) 2317 Jefferson St.

15 Filed JAN 10 1921 ROBERT I. LEVY Registrar

Burial Permit Oliver

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany. 8th, 1921, to Jany. 9th, 1921, that I last saw h.. alive on Jany. 8th, 1921, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Fatty Enteritis

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ....yrs. ....mos. 2 Hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) D. W. Jones, M. D.

1/10/1921 (Address) 1013 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Jan. 11 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bates

2449714

HEALTH DEPARTMENT—CITY OF BALTIMORE

2449714

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Eastmean ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarance Bates

(a) RESIDENCE. NO. 2412 Eastmean ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bettie Bates

6 DATE OF BIRTH (month, day, and year) Nov 16 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Henry Bates

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Fredrick Co Md

12 MAIDEN NAME OF MOTHER Caroline Dawson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore City Md

14 Informant Bessie Bates
(Address) 2412 Eastman st Baltimore Md

15 Filed JAN 10 1921 ROBERT F KRAUTER Registrar
Burial Permit Issued

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to Jan 7 1921, that I last saw him alive on Jan 7 1921, and that death occurred, on the date stated above, at 1.60 A. m.

The CAUSE OF DEATH* was as follows:

Uremia
Original pneumonia.
Hypostatic (duration) yr. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis
dilated + large heart.
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H L McCarty, M. D.

1-8, 1921 (Address) 317 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Luke's Cemetery	Jan 10 1921
20 UNDERTAKER Reisterstown Md	ADDRESS Reisterstown Md
H F Ellis	

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49715 HEALTH DEPARTMENT—CITY OF BALTIMORE D49715

CERTIFICATE OF DEATH.

9 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Bolton ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Eleanor Fisher

(a) RESIDENCE. No. 1711 Bolton ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? 19 yrs. 4 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) September 10-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	19	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Girl

(b) General nature of industry, business, or establishment in which employed (or employer) attending

(c) Name of employer Goucher College

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ferdinand C. Fisher

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mabel L. Herman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr F. C. Fisher (Father)
(Address) 1711 Bolton Street

15 Filed JAN 10 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 9, 1921, that I last saw her alive on Jan 9, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
secondary Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Streptococcus + Diphtheria

(Signed) Stanton McAdams, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Jany 17 1920.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49716

CERTIFICATE OF DEATH.

REGISTERED NO. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Lansing Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie C. Hilbinger

(Residence in Baltimore: No. 1711 Lansing Ave St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. 1, 1878 (Month) (Day) (Year)

7-AGE, 42 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Balto. Maryland

PARENTS.

10-NAME OF FATHER, Frederick Tiley

11-BIRTHPLACE OF FATHER (State or Country), Balto. Maryland

12-MAIDEN NAME OF MOTHER Mary B. Zimmerman

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Hilbinger

(Address) 1711 Lansing St.

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

JAN 10 1921

important. See Instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191....., to ....., 191.....,
that I saw her alive on Jan 8 1921,
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY
(Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Edward J. Avery M. D.

Jan 8, 1921 (Address) 1603 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 11, 1921

20-UNDERTAKER Fred Lasch & Sons

ADDRESS Fullerton Md.

Spec.—8-24-14—M. & T.—2000 Blks.

D.49717 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49717

81

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2543 Hollins ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Watts

(Residence in Baltimore: No. 2543 Hollins St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 1st, 1830 (Month) (Day) (Year)

7-AGE, 90 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), A.A. County Md

PARENTS.

10-NAME OF FATHER, Isaiah Watts

11-BIRTHPLACE OF FATHER (State or Country) a.a. County Md

12-MAIDEN NAME OF MOTHER Ruth arnold

13-BIRTHPLACE OF MOTHER (State or Country) a.a. county md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. A. Watts

(Address) Harrisberg Pa

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

ANT 0 1921

Important. Information required by law.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 7, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1919, to Jan 7 1921, that I saw h[illegible] alive on Jan. 7 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
without Hemiplegia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Old Age.
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard W Jones M. D.

1-8, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. E. Cem ELKRIDGE

DATE OF BURIAL, 1-11-21, 191..

20-UNDERTAKER Roberts Brokerson

ADDRESS CALHOUN HOLLINS ST

Spec.—8-24-14—M. & T.—2000 Bks.

D.49718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49718

CERTIFICATE OF DEATH.

REGISTERED NO. C 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 N. Montford Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah V Chaney

(Residence in Baltimore: No. 1214 N. Montford ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widow

6-DATE OF BIRTH, Nov 29 (Month), 1848 (Day) (Year)

7-AGE, 72 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House [illegible]
(b) General nature of industry, business, or estsblishment in which employed (or employer) ..... Work

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Chaney

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER, Sarah Clemens

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lottie Stone

(Address) 1214 N Montford Ave

15-

Filed JAN 10 1921, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1920, to Jan 8 1921, that I saw h[illegible] alive on Jan 8 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Frederick E. Hanes M. D.

Jan 9, 1921 (Address) 1301 N Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL, Jany 11 1921

20-UNDERTAKER Robt J Johnson

ADDRESS 144 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

Willie Scott

D.49719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49719

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Morgan St Hillsview St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Willie Scott

(Residence in Baltimore: No. Morgan Sta W. Winans St.; 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1880
(Month) (Day) (Year)

7-AGE About 40 yrs. ~ hrs. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife 37
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Geo Bell

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Louisa Kenney

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Scott

(Address) Morgan & W. Winans Md

15-

JAN 10 1921 Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Unknown 1 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1. 8 1921, to 1-8- 1921, that I saw h[er] alive on 1. 8 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Thos B Hall M. D.

1-10-, 1921 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, 1-12, 1921.

20-UNDERTAKER Mrs Geo H Hooper

ADDRESS 406 W Conway

Important. See instructions on back of this

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49720 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49720

CERTIFICATE OF DEATH. 117-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fisher

(a) RESIDENCE. No. 853 Ostend St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Jan 10 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1921, to January 7, 1921, that I last saw her alive on January 7, 1921, and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Peritonitis, general (over)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) V. Bateman, M. D.

1/7/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Arthur Cemetery	1/11 1921
20 UNDERTAKER	ADDRESS
Jno. Gerth Hooks	400 W Camden St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49721 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49721

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Poppleton ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie McLaughlin.

(a) RESIDENCE. NO. 112 S. Poppleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John McLaughlin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Nocken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John McLaughlin. (Address) 112 S. Poppleton St.

15 Filed . 19 Robert F. Harrison, Registrar

No. 01991 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Jan. 7. 1921, that I last saw h[illegible] alive on Jan. 7. 1921, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Chas. Norton. M. D.

1/8, 1921 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Jan. 11 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1727 Eight St.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.419722 HEALTH DEPARTMENT—CITY OF BALTIMORE D.419722

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2834 Clifton ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Henry Hummel

(a) RESIDENCE. No. 2834 Clifton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ Chas. E. Hummel

6 DATE OF BIRTH (month, day, and year) Mar 14-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Martinsburg West Va.

PARENTS

10 NAME OF FATHER Christian Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER Martha Ann Lill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas. E. Hummel

(Address) 2834 Clifton Ave.

15 FILED JAN 10 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1920, to Jan. 9, 1921, that I last saw h[illegible] alive on Jan 8, 1921, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anaemia

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Paines Brown, M. D.

1/9, 1921 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 12 1921
20 UNDERTAKER	ADDRESS
H. J. France & Son	637 Hanover St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.49723 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49723

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 W. Barre ST.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel J. Batton

(a) RESIDENCE. No. 1007 W. Barre ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. 29 ds. How long in U. S., if of foreign birth? 11 yrs mos. 29 ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 - 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~000~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. M. Batton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ella A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm. M. Batton

(Address) 1007 W. Barre ST.

15 Filed ....., 19.... Robert F. Barrison, Registrar

Burial Permit Clerk

JAN 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan ~~10~~ 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th 1920, to Jan 8 1921, that I last saw h[er] alive on Jan 8th 1921, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J E Poulton M. D.

1/10. 1921 (Address) 654 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem.	Jan 11 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	1039 Hanover St

TION is very important. See instructions on back of certificates.

D.49724 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49724

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 318 S Garrison Lane, ST. 20 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William U. M. Balke

(Residence in Baltimore: No. 318 S. Garrison Lane St. 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. November 7, 1883
(Month) (Day) (Year)

7-AGE. 38 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... R.R. Man
(b) General nature of industry, business, or establishment in which employed (or employer)..... 073

9-BIRTHPLACE, (State or Country). Phila - Pa.

PARENTS.

10-NAME OF FATHER. Wm. M. Balke.

11-BIRTHPLACE OF FATHER (State or Country). Pa.

12-MAIDEN NAME OF MOTHER Clara Roberts.

13-BIRTHPLACE OF MOTHER (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida S. Balke.

(Address) 318 S. Garrison Lane

15-

Filed JAN 10 1921, 191.

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John P. Harrison M. D.
(Coroner)

Jan 10, 1921. (Address) 3632 Rolandvue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. Baltimore

DATE OF BURIAL. Jan 11 1921.

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49725 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49725

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1345 Ramsay St ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa A Elliott

(a) RESIDENCE. No. 403 So. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. C. Elliott

6 DATE OF BIRTH (month, day, and year) Aug 8 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of Indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant J C Elliott (Address) 1403 So Calhoun St

15 Filed JAN 10 1921 Robert P. Harrison Registrar

So Mount 1520 Hollins St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Jan 9, 1921, that I last saw h[illegible] alive on Jan 9, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? I don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph E. Moore, M. D.

1/10, 1921 (Address) 520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 12 1921
20 UNDERTAKER Wm Cook	ADDRESS N & G Ave

mation should be carefully supplied. It may be properly classified. It is important that it CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49726 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1576 Linden Ave ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert LeRoy West Jr

(a) RESIDENCE. No. 1576 Linden Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8.	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herbert L. West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Inez Gould

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 Informant Eugene West.

(Address) 1576 Baltimore St

15 Filed . 19 Registrar

107921 Burial Permit Clerk.

Mc Henry 1609 Linden Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Jan 10, 1921, that I last saw h[illegible] alive on Jan 10, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diphtheria - Nasal

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Throat Dipth Lab

(Signed) Frederick McKelvey, M. D.

. 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 11 19

20 UNDERTAKER Lowe Cook ADDRESS 502 E Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49727 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49727

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 N Park St - ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Grace Leesner

(a) RESIDENCE. NO. 1514 N Park St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	S -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct-9-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General natore of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edwin J. Leesner

11 BIRTHPLACE OF FATHER (city or town) Balt-
(State or country) Md

12 MAIDEN NAME OF MOTHER Clara Wetherhold

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country) Md.

14 Informant Edwin J. Leesner
(Address) 1514 N. Park St

15 Filed JAN 10 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, 19.... to Jan 10, 19 21,
that I last saw her alive on Jan 10, 19 21,
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Urinary tests

(Signed) A D Maedonald, M. D.

(Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 12- 1921

20 UNDERTAKER Wm Cook — ADDRESS [illegible]

mation should be carefully supplied. Exact statements are required by law. Certificates of DEATH must be properly classified. Each statement should be carefully supplied. Exact statements are required by law. Certificates of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are required by law. Certificates of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49728 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49728

CERTIFICATE OF DEATH. 61

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud Wheeler.

(a) RESIDENCE. NO. 521 W. Fulton Ave. St., City. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	"	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk. 109
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Wheeler.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Susan N. Stafford

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant Mother Mrs L. Wheeler.
(Address) 521 W. Fulton Ave City

15 Filed JAN 10 1921, 19 Robert P. Harrison.
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June. 8, 1921, to June 10, 1921, that I last saw h.. alive on June 10, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) W. H. Craig M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Jan 12-1921

20 UNDERTAKER William Cook — ADDRESS 502 E. Hath

CAUSE OF DEATH in plain terms, and TION is very important. See instructions on back of certificates.

D.49729 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49729

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 721 Bay St. ST.: 13 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. Bourne.

(Residence in Baltimore: No. 721 Bay St. St. 0 yrs., 0 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Infant

6-DATE OF BIRTH, Jan. (Month) 9 (Day), 1921 (Year)

7-AGE, 0 yrs. 0 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto city Md.

PARENTS.

10-NAME OF FATHER Samuel Bourne

11-BIRTHPLACE OF FATHER (State or Country), Irrland.

12-MAIDEN NAME OF MOTHER Mary A. Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Balto city Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Bourne

(Address) 721 Bay St.

15- Filed JAN 10 1921, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk

CAUSE OF DEATH is plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to his death on the day stated above. 855 am

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D. (Coroner.)

Jan 10, 1921. (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys Cem Hampden — DATE OF BURIAL, Jan. 11, 1921

20-UNDERTAKER Walter Davis — ADDRESS 3307 Pams St

Spec.—5-19-13—M. & T.—500 Bks.

1049730

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049730

CERTIFICATE OF DEATH.

18

REGISTERED NO. C.....

1-PLACE OF DEATH 1340 S Charles

CITY OF BALTIMORE: (No. 1340 S Charles ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr William H. Siegert

(Residence in Baltimore: No. 1340 S. Charles St.; — yrs., — mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 15 (Month) (Day), 1867 (Year)

7-AGE, 53 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), A A Co Md

PARENTS.

10-NAME OF FATHER, Peter Clemens

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Matilda C. Dantzer

13-BIRTHPLACE OF MOTHER (State or Country), A A Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes I. Siegert

(Address) Mitchellville Md

15- JAN 11 1921 Filed....., 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 10 1921, that I saw h— alive on Jan 10 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic pancreatitis,

Acute Dilatation of Stomach

(Duration)....yrs....1....mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration)....yrs.....mos. 10 ds.

(Signed) H. Berry Spence M. D.

Jan 10, 1921 (Address) 1508 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 54 yrs. ....mos. 2 ds.

Where was disease contracted, if not at place of death? Mitchellville Prince Georges Co Md

Former or usual residence Mitchellville Md

19-PLACE OF BURIAL OR REMOVAL, Evergreen A A Co Md — DATE OF BURIAL, Jan 11..., 1921

20-UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson ave

important. See instructions on back of certificate.

D49731 HEALTH DEPARTMENT—CITY OF BALTIMORE D49731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 273 N. Eden St. 5 150 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cucumo Palumbo

(Residence in Baltimore: No. 273 N. Eden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, 7/1/20 (Month) (Day) 1 (Year)

7-AGE, ...yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, S. Palumbo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Katie ~~Paglio~~ Dilio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Dilio

(Address) 273 N. Eden

15- JAN 11 1921 ROBERT P. KRAUTER
Filed....., 191. REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Medical Negligence

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. T. Riley M. D.
(Coroner.)
Jan 10, 1921 (Address) 1633 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincent's Cemetery	1/12/21, 19....
20-UNDERTAKER Geo. J. Peter.	ADDRESS 1735 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

049732 HEALTH DEPARTMENT—CITY OF BALTIMORE 049732

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Bruce ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Stevenson Green Jr.

(Residence in Baltimore: No. 506 N. Bruce St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1855 (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor

9-BIRTHPLACE, (State or Country), Petersburg Va.

PARENTS.

10-NAME OF FATHER, Sam. Stevenson Green

11-BIRTHPLACE OF FATHER (State or Country), Petersburg Va.

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Petersburg Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lou Green

(Address) 506 N. Bruce St.

15- JAN 11 1921 ROBERT J. KRAUTER

Filed....., 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 8 1921, that I saw him alive on Jan 8 1921, and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Thos. C. McCarthy M. D.

Jan 9, 1921 (Address) 906 N. Bruce St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Zion — DATE OF BURIAL, Jan. 11, 1920

20-UNDERTAKER John H. Scadin — ADDRESS 142 W. Pratt St

Improvements. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D49733 HEALTH DEPARTMENT—CITY OF BALTIMORE D49733

CERTIFICATE OF DEATH.

REGISTERED No. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N. Bruce ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H Randolph, Jr.

(Residence in Baltimore: No. 803 N. Bruce St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col	Baby

6-DATE OF BIRTH, 7 (Month) 21 (Day), 1921 (Year).

7-AGE, ...yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. city

PARENTS.

10-NAME OF FATHER, James H. Randolph

11-BIRTHPLACE OF FATHER (State or Country), No. Ca

12-MAIDEN NAME OF MOTHER Pearline Miller

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Randolph

(Address) 803 Bruce St

15- Filed JAN 11 1921, 191.... ROBERT J. BRAUTIGAM Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 9 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 1-4-21 191..., to 1-9-21 191..., that I saw h[illegible] alive on ..... 191..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

.....

.....

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition, Rickets

..... (Duration) ....yrs. 5 mos. ....ds.

(Signed) F. M. Cadezo M. D.

1-10-21 (Address) 1524 O'Hillary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Jan. 11, 1921.

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 Carey St

Cause of death must be stated in plain terms. Indefinite answers, such as "Fever," "Heart Failure," "Old Age," "Dropsy," "Cancer," "Consumption," are insufficient. Contributory (secondary) causes should be stated if they existed. Violent deaths must be fully explained. Physicians are required to report promptly all cases of death coming under their professional care. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L049734 L049734

CERTIFICATE OF DEATH.

31 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1120 Mc Culloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter F. Jackson

(Residence in Baltimore: No. 1120 Mc Culloh St.; Lifetime yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, July (Month) 27 (Day), 1914 (Year)

7-AGE, 1 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William E. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Bertha Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Jackson (Father)

(Address) 1125 Mc Culloh St

15- ROBERT F. KRAUTER
Filed JAN 11 1921, 191.... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1914, to Jun 10 1921, that I saw him alive on Jun 9 1921, and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Tuberc. Mesenterica

Septicemia (Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilson D. Kemp M. D.

June 10, 1921 (Address) 1425 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Jan. 11, 1921

20-UNDERTAKER Wm. M. Johnson

ADDRESS 1234 Eutaw St

Important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.- 1000 Bks.

D 49735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49735

82

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Skinner

(a) RESIDENCE. No. 807 Ashland Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60 ?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible] 070

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) [illegible]
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown 1/9/21

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country) Va

14 Informant Hospital Records,
(Address) New City Hospital.

15 FILED JAN 11 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 8, 19 21, to January 9, 19 21, that I last saw her alive on January 9 19 21, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) — [illegible] M. D.

1/9/21 19 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 12 1921
20 UNDERTAKER	ADDRESS 1725
Mrs Robt a Elliott	Ashland Ave

THIS is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

L049736 L049736 152

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Fait Ave ST.: 26 WARD)

2-FULL NAME Marion C. Lucas.

(a) RESIDENCE. NO. 3803 Fait Ave ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 9-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 3 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Marion C. Lucas

11 BIRTHPLACE OF FATHER (city or town) Pinlork
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Fischer

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mary Lucas.
(Address) 3803 Fait ave

15 Filed JAN 11 1921 BOWEN I. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from
on Jan 4, 1921, to ....., 19....,
that I last saw h[illegible] alive on Jan 9, 1921,
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Contracted Pelvis.
Forceps Delivery ? Fatal

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

1/9/1921 (Signed) Leo Kaltenbach, M. D.
(Address) 3055 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan. 10 1921
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH. Physician must fill in this line. See instructions on back of certificates. TION is very important.

049737 HEALTH DEPARTMENT—CITY OF BALTIMORE 049737

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 622 Ensor St.: 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Brown

(Residence in Baltimore: No. 622 Ensor St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Baltimore Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Schilling

(Address) 1126 E Monument st

15- Filed JAN 11 1921 191.... ROBERT B KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Bowles M. D.
(Coroner.)

1-8-21, 191... (Address) 25 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
1st Ger. Reformed 14th Cemetery	Jan 11th 1921
20-UNDERTAKER	**ADDRESS**
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH must be plainly written, and all questions answered as far as possible. It is important. See instructions on back of certificate.

Morgan

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

No 49738

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 Lemmon St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lewis Toney

(a) RESIDENCE. NO. 1327 Lemmon St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Toney

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman 674

(b) General nature of industry, business, or establishment in which employed (or employer) Loading and unloading ships

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. W. Toney

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) St. Marys Co (State or country) Md.

14 Informant Martha Guider (Aunt)
(Address) Baltimore Md 11N. Bruce St.

15 Filed JAN 11 1921 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8 1921 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24th, 19 20, to Jan 8th 1921 19, that I last saw him alive on Jan. 6th 1921, 19, and that death occurred, on the date stated above, at 3. A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonart Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 11 1921
20 UNDERTAKER	ADDRESS 11 W or.
Brown & Buckland	Lexington

CAUSE OF DEATH must be filled in by physician. See instructions on back of certificate. TION is very important.

049739 HEALTH DEPARTMENT—CITY OF BALTIMORE 049739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 132 1/2 S Clement st. ST.; 24 WARD) 7

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura C. Page.

(Residence in Baltimore: No. 132 1/2 S. Clement st. St.; yrs., 8 mos. r ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, October 1st. 1842, 1 (Month) (Day) (Year)

7-AGE, r8 yrs. 3 mos. r ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Lillian Welsh

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary L. Biscoe.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Fosenay. (daughter)

(Address) 132 1/2 S Clement st.

15- Filed JAN 11 1921 191.... ROBERT F KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9th. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs....mos....ds.

(Signed) Otto M Reinhardt M. D. (Coroner.)

Jan. 9th, 1921 (Address) 10 E. Chas. st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Jan 11 1921

20-UNDERTAKER F. B. Kespert ADDRESS 2236 Eutaw Av

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0449740

HEALTH DEPARTMENT—CITY OF BALTIMORE

0449740

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1249 Hull ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugo Huth

(a) RESIDENCE. No. 1249 Hull ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Huth

6 DATE OF BIRTH (month, day, and year) April 22-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara Huth

(Address) 1249 Hull St.

15 Filed JAN 11 1921 ROBERT I. [illegible] Registrar

Burial Permit Clerk

Removed 54 Washington

CAUSE OF DEATH must be plainly described. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30th 1913 to Jany 9th 1921 that I last saw h[illegible] alive on Jany 8th 1921 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Singewald M. D.

1/9, 1921 (Address) 5 N. Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 11 1920

20 UNDERTAKER Geo. A. Gerbig ADDRESS 2001 W. Baltimore St.

Spec.—8 24-14—M. & T.—2000 Bks.

049741

HEALTH DEPARTMENT—CITY OF BALTIMORE

049741

CERTIFICATE OF DEATH.

REGISTERED NO. C 115

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Frankel

(Residence in Baltimore: No. 1034 E. Lombard St St.; ~~5~~ yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unkon (Month) (Day), 1866 (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Ho

9-BIRTHPLACE, (State or Country) Russia

PARENTS.

10-NAME OF FATHER, Unkon

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unkon

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Balto St

15- Filed JAN 11 1921 191 ROBERT E KRAUTER Registrar

Burial Permit Issued

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 6 1921, to January 10, 1921, that I saw him alive on ~~last~~ January 10, 1921, and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder

Operation

(Duration) 1 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Charles A. Levy M. D.

1-10, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State 6 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, Jan 11, 1921

20-UNDERTAKER Jack Levis

ADDRESS 1411 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49742 64 49742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Eutaw Place St. 14 Ward)

2-FULL NAME Annie Stein

(a) RESIDENCE. No. 2005 Eutaw Place Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis Stein

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Chaneson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Liba —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Louis Stein (Address) 1411 E Balto St

15 Filed JAN 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10-h 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 31-h 1920 to Jan 10 1921 that I last saw h-s alive on Jan 10 1921 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Last (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2005 Eutaw Place

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Previous dis

(Signed) V. Mac Williams, M. D.

, 19 (Address) 60 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herman Sinai	1/11 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Eks.

L049743 HEALTH DEPARTMENT—CITY OF BALTIMORE L49743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2307 Hunter St ST.: 17 WARD) 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Berry

(a) RESIDENCE. No. 2307 Hunter St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Unknown to me)

6 DATE OF BIRTH (month, day, and year) Unknown, 188

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Wm Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Anderson (Address) 2307 Hunter St

15 Filed JAN 11 1921, 19 [illegible] Registrar

Burial Permit Giert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 9, 1921, that I last saw h[illegible] alive on Jan 9, 1921, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Nephritis and Cardiac Insufficiency

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? nd

Did an operation precede death? nd Date of nd

Was there an autopsy? nd

What test confirmed diagnosis? Urinary & Clinical

(Signed) Ged L Dalle, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	January 11. 1921
20 UNDERTAKER Samuel T Hendley	ADDRESS 578 W. Baltimore

CAUSES OF DEATH. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49744

HEALTH DEPARTMENT—CITY OF BALTIMORE

L49744

CERTIFICATE OF DEATH.

37

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 E Oliver ST.; 8 WARD)

2-FULL NAME Charles Louis Baker

(a) RESIDENCE. No. 2134 E Oliver ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Evelyn Baker

6 DATE OF BIRTH (month, day, and year) June 6, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant 009

(b) General nature of industry, business, or establishment in which employed (or employer) U. R. & E. Co.

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Evelyn Baker (Address) 2134 E Oliver St

15 Filed JAN 11 1921 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1920, to Jan. 9, 1921, that I last saw h... alive on Jan. 8, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Lues.

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paresis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Wassermann +++.

(Signed) George G. Bamden, M. D.

1,9, 1921 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 12 1921

20 UNDERTAKER J Herwig & Co

ADDRESS 2008 Orleans

CAUSE OF DEATH must be plainly written, so that it may be understood on any part of the certificate. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49745 D49745 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 519 S 16th ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leonard

(a) RESIDENCE. NO. 519 S 16th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 30-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	6	8	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daniel Leonard (Address) 519 S 16th St

15 JAN 11 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Jan. 8, 1921, that I last saw h[illegible] alive on Jan. 8, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

5 to 7 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Evidence

(Signed) H. C. Hill, M. D.

Jan 9, 1921 (Address) 3508 Bank St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 11 1921

20 UNDERTAKER J. Herweg & Co ADDRESS 2008 Eden

CAUSE OF DEATH should be stated by the physician in plain English. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Esterka

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49746 D49746

CERTIFICATE OF DEATH.

105

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 Church ST. Curtis Bay 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Esterka

(Residence in Baltimore: No. 23 Church St.; 4 yrs., ... mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Jan 2, 1917 (Month) (Day) (Year)

7-AGE, 4 yrs. ..... mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Esterka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Laura Kovacs

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John Esterka

(Address)..... 23 Church St

15- JAN 11 1921 ROBERT E KRAUTER

Filed ..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Jan 10 1921, that I saw h[illegible] alive on Jan 10 1921, and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. 1 hr. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Epilepsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. D. Horton M. D.

Jan 10, 191.. (Address) 1 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Jan 12, 1921

20-UNDERTAKER Frank Enoch & Son — ADDRESS 1116 E Baltimore

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kulhanek.

1049747

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049747

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 78 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Kulhanek

(a) RESIDENCE. ~~No.~~ Baltimore Md. 808 N Carlton St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? Dont Know yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Kulhanek - (?)

6 DATE OF BIRTH (month, day, and year) Not Known -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt -	56	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Butchering

(c) Name of employer Dont Know

9 BIRTHPLACE (city or town) (State or country) Ronov (?) Bohemia

PARENTS

10 NAME OF FATHER Karl Kulhanek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know - Bohemia

12 MAIDEN NAME OF MOTHER Mrs Kulhanek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know Bohemia -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 Filed JAN 11 1921 ROBERT J. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th 1918 to Jan 8th 1920, that I last saw him alive on Jan 8th 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis - with Cardiac Complication - Endocarditis -

abt (duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia - (Pneumonia)

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Jan 9th 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Jan 11 1921

20 UNDERTAKER Frank E Krack Son ADDRESS 1916 Eastlandh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information on back of certificates. TION is very important. See instructions on back of certificates.

Mary R. Hoya

D49748

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D49748

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 21 S. Rose ST.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R. Hoya

(Residence in Baltimore: No. 21 S. Rose Lifetime St.: 30 yrs. ..... mos. ..... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Nov (Month) 1 (Day) ..... (Year)

7-AGE: 30 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Robert Lean

11-BIRTHPLACE OF FATHER (State or country): Balt

12-MAIDEN NAME OF MOTHER: M Kroyer

13-BIRTHPLACE OF MOTHER (State or country): Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hoya

(Address) 21 N Rose St

15- Filed JAN 11 1921 191 ..... ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920 to Jan 9 1921, that I saw h e alive on Jan 7, 1921, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Respiratory failure

(Duration) ..... yrs. ..... mos. one ds.

(Signed), G. A. Hinke, M. D.

Jan 10, 1921 (Address) 801 N. Chas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer | DATE OF BURIAL: Jan 11, 1921

20-UNDERTAKER: Frank Cracken | ADDRESS: 1116 Eastland

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049749 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049749

CERTIFICATE OF DEATH. 82

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Ward St ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Wheatley

(a) RESIDENCE. NO. 1129 Ward St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W

6 DATE OF BIRTH (month, day, and year) Oct 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Texas (State or country) Md

PARENTS

10 NAME OF FATHER Michael Burke

11 BIRTHPLACE OF FATHER (city or town) Texas (State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Texas (State or country) Md

14 Informant M J Kelley (Address) 1129 Ward St

15 Filed JAN 11 1921 BOTTERY & KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 9, 1921, to Jany 10, 1921, that I last saw h.. alive on Jany 10, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Varicose Veins & Arteri Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen d Strain, M. D.

, 19 (Address) 1227 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Jan 13 1921

20 UNDERTAKER John A Fields ADDRESS 1201 W Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049750 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049750

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S. Kenwood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Hundt

(a) RESIDENCE. No. 804 S. Kenwood Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 - 1834

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. v40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Katharine Henderson

(Address) 804 S. Kenwood ave.

15 Filed JAN 11 1921 ROBERT J. LAUTER Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to Jan 9, 1921, that I last saw h[illegible] alive on Jan 9, 1921, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

Jan 11 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan 12th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeller	403 S. Wolfe St.

D. 49751 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49751

CERTIFICATE OF DEATH. 167

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abbie Brookman

(Residence in Baltimore: No. 770 Sarah ann St 20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John Walters

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penn ave

15- Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JAN 11 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~or~~ ~~inquiry.~~) ..... found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

a few hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accidentally caught fire

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

1-11-, 1921 (Address) 11 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DW Cemetery DATE OF BURIAL, Jan 12, 1921

20-UNDERTAKER Daniel Easton ADDRESS 916 Penn ave

16.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49752 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49752

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 S. 16th St. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward G. Vogler

(a) RESIDENCE. No. 500 S. 16th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Vogler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Seebold

13 BIRTHPLACE OF MOTHER (city or town) New Berlin (State or country) Union Co., Pa.

14 Informant Charles L. Clarkson (Address) 1811 N. Caroline St.

15 Filed ..... 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/8/21, 19..., to 1/9/21, 19..., that I last saw him alive on 1/9/21, 19..., and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick H. Wessman M. D.

1/11/21 (Address) 1919 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Jan 12 1921

20 UNDERTAKER Jos. Block ADDRESS 1003 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49753 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49753

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.: 7 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dunmoyer

(a) RESIDENCE. NO. ..... ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	⌐

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ⌐

6 DATE OF BIRTH (month, day, and year) Jan. 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day ~~2~~ hrs. or ~~12~~ min.
			1 hr.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ⌐ ood

(b) General nature of Industry, business, or establishment in which employed (or employer) ⌐

(c) Name of employer ⌐

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Richard Dunmoyer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Pennsylvania?

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pennsylvania

14 Informant T.C. Lamble M.D.
(Address) Johns Hopkins Hosp.

15 Filed JAN 11 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to Jan 9, 1921, that I last saw h[illegible] alive on Jan. 8, 1921, and that death occurred, on the date stated above, at 1:50 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ⌐

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ⌐

Did an operation precede death? ⌐ Date of ⌐

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy N. Cromwell, M. D.

1/9, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JAN 10 1921 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items. Use ditto marks only when they will be understood. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49754 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49754

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH (or number) REGISTERED NO.

CITY OF BALTIMORE: (No.) Mill Lane St.: 28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Henry Smith

(a) RESIDENCE. No. 7 Mill Lane St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) March 21 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Gd

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maranda Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Smith.
(Address) Seven Mile Lane

15 Filed ..... 19 Robert P. Harrison Registrar

JAN 11 1921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1918, to Jan 9, 1921, that I last saw him alive on Jan 9, 1921, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo H Holland MD, M. D.

1/11, 1921 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Jan 12 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Hanover Hillcrest

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D.49755

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49755 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3435 Ash St. ST.; 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon H. Bryant

(a) RESIDENCE. No. 3435 Ash St. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1-1920

7 AGE — Years | 2 Months | 9 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. H. Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Effie M. Yingling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant (Address): Mrs. Effie M. Bryant 3435 Ash St.

15 Filed JAN 11 1921, 19..... Robert T. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1921, to Jan 10th, 1921, that I last saw h.. alive on Jan 10th, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Ill defined

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) B. A. Fellows, M. D.

1/ 11, 192 (Address) 1029 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys Hampden	Jan. 12 1921
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	363 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are absolutely necessary. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49756 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49756

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Toti

(a) RESIDENCE. No. 245 S. Caroline st. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerry Toti

6 DATE OF BIRTH (month, day, and year) 1894 March 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Marshall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Olivia Eubanks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address) Robert M. T. Harrison.

15 Filed JAN 11 1921, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to Jan. 10, 1921, that I last saw her alive on Jan. 10, 1921, and that death occurred, on the date stated above, at 10.40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, Xray

(Signed) L. T. Rigney, M. D.

1-11-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent

DATE OF BURIAL January 12 1921

20 UNDERTAKER Wendell Dippel & Son

ADDRESS [redacted]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

D.49757 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 106 N Fremont St. ST.: 18 WARD) 79

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Fluher

(Residence in Baltimore: No. 106 N Fremont St. St.; 4 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Feb (Month) 22 (Day), 1847 (Year)

7-AGE, 73 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J. A. Hilley

(Address) 106 N. Fremont Ave

15- Filed JAN 11 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or inquiry.~~) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) ..... yrs. Dont Know mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Known

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. H. Forrest M. D. (Coroner.)

1-11-, 1921 (Address) 117 N Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Jan 13, 1921

20-UNDERTAKER Mr & Mrs John W Temple

ADDRESS 801 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49758 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49758

CERTIFICATE OF DEATH.

79 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home of Incurable ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Burton.

(a) RESIDENCE. No. 1738 E. Fairvale ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Joseph A. D. Burton.

6 DATE OF BIRTH (month, day, and year): Dec. 24-1849

7 AGE: Years 71 | Months — | Days 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Martinsburg W Va.

PARENTS

10 NAME OF FATHER: Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Roland Burton.
(Address): 303 N. Carey Street

15 Filed JAN 11 1921 Robert P. Harrison Registrar

Dr. Mayo - Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10 - 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jany 3 1921 to Jany 10 1921, that I last saw her alive on Jany 10 1921, and that death occurred, on the date stated above, at about 2 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy, Cardiac

Decompensation 3 (duration) yrs. mos. — ds.

CONTRIBUTORY (secondary) Senile insufficiency

Arteriosclerosis (duration) ? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Probably Baltimore

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Inspection, percus, auscult.

(Signed) Wm B Mayo M. D.

, 19 (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Jan. 12 1921

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks.

Ferguson

D 49759 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Talbot Av. ST.; 17 WARD) REGISTERED NO. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Ferguson

(Residence in Baltimore: No. 3120 Talbot Av St., Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, October 9th, 1918
(Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER Victor Ferguson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Rebecca Cook.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Ferguson

(Address) 3120 Talbot - St Wash

15. JAN 12 1921 ROBERT I KRAUTER

Filed....., 191.... Burial Permit Clerk
Registrar

CAUSE OF DEATH in plain terms, as that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 10th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5th 1921, to Jan 10th 1921, that I saw her alive on Jan 10th 1921, and that death occurred, on the date stated above, at 1.30P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Washington Lucas M. D.

Jan 10th, 1921 (Address) 404 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery

DATE OF BURIAL, Jan 12, 1921.

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 725 Ashland Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49760

CERTIFICATE OF DEATH.

24

1-PLACE OF DEATH U S PUBLIC HEALTH SERVICE HOSPT #56 REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTIMORE, MD. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRED CLARK

(a) RESIDENCE. No. US PUBLIC HEALTH SERVICE HOSPT #56 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34 yrs	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): --------

(c) Name of employer: --------

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edgar T. Krenbuck (Address) Fort McHenry, Balto. Md.

15 Filed JAN 12 1921 MOSES J. KLAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1921, to January 8, 1921, that I last saw him alive on January 8, 1921, and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus

Over

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY --- (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of --

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Thomas R. Payne, M.D. Senior Surgeon

Jan 11 1921 (Address) Fort McHenry, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 19 21

20 UNDERTAKER: S. Simpson & Bro — ADDRESS 1127 E Balto st

(Over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

By phone - Wood splinter
in left thumb under nail

Spec.—8-24-14—M. & T.—2000 Bks.

D49761 HEALTH DEPARTMENT—CITY OF BALTIMORE D49761

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 3419 Roland Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Dearing

(Residence in Baltimore: No. 3419 Roland Ave St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Jan (Month) 11 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 1 ds.	10 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Clemence Dearing

11-BIRTHPLACE OF FATHER (State or Country), Elkridge Md

12-MAIDEN NAME OF MOTHER, Viola Elizabeth Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Clemence T. Dearing

(Address)... 3419 Roland Ave

15-JAN 12 1921 ROBERT F. BAUTER

Filed....., 191.... Registrar of Births

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1921, to Jan 11 1921, that I saw h.r alive on Jan 11 1921, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

6½ months gestation

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)..... C. J. Davis M. D.

Jan 11, 1921 (Address) 800 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden | DATE OF BURIAL, Jan 14, 1921

20-UNDERTAKER Edenwald & Son | ADDRESS Eastmt Ave

CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49762

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 E. 28th St ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F Markert

(a) RESIDENCE. No. 1722 E 28th St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ Pauline V Markert

6 DATE OF BIRTH (month, day, and year) Mar-3-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker 017

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carl Markert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William L Markert

(Address) 3216 Hartford ave

15 Filed JAN 12 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10- 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1920, to Jan 10, 1921, that I last saw h[illegible] alive on Jan 9-, 1921, and that death occurred, on the date stated above, at 8:40 a m.

The CAUSE OF DEATH* was as follows:

1st Carcinoma

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Laryngeal tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Sputum.

(Signed) C E Burton, M. D.

1/11. 1921 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 13th 1921
20 UNDERTAKER	ADDRESS
J Schloman & Son	Fairmount Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D49763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49763

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 S Thorpe ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Schmidt. Jr.

(Residence in Baltimore: No. 1045 S. Thorpe, St.; ....yrs., mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 21st, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William C. Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Sophia Otte

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William C. Schmidt

(Address) 1045 S. Charles St

15- JAN 12 1921 Filed....., 191.. ROBERT E. LAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 — 1921, to Jan 11 — 1921, that I saw h[illegible] alive on Jan 11 — 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) 1 yrs. — mos. 1 ds.

CONTRIBUTORY, (Secondary) Probably

(Duration) — yrs. 1 mos. — ds.

(Signed) H. Hurt Brooke M. D,

Jan 11, 1921. (Address) 1340 S Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 4 yrs. mos. ....ds.

Where was disease contracted, if not at place of death? City

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem.	Jan 12, 1921
20-UNDERTAKER	ADDRESS
J. Schloman & Son	1039 Hanover St

CAUSE OF DEATH: In plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

0049764 HEALTH DEPARTMENT—CITY OF BALTIMORE 0049764

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1823 Lemmon ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Young

(a) RESIDENCE. No. 1823 Lemmon ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 5 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 6 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Young

11 BIRTHPLACE OF FATHER (city or town) Havalon
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura C Gunstler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Robert Young
(Address) 1823 Lemmon St

15 Filed JAN 12 1921 ROBERT P. LAMUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 11 1921, that I last saw him alive on Jan 10 1921, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Morris Reese, M. D.

Jan 11, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 12 1921

20 UNDERTAKER Harry L. Hitzler — ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

145 Bal 2049765

HEALTH DEPARTMENT—CITY OF BALTIMORE

2049765

CERTIFICATE OF DEATH.

X 91-126

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp (ST.) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oren P Chapman

(a) RESIDENCE. No. 1860 E 73rd St (or) Edwd St (or) Ohio St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Austin Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Pershing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Hospital Record
(Address) Johns H.

15 JAN 12 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 11 1921, that I last saw h[illegible] alive on Jan 11 1921, and that death occurred, on the date stated above, at 11 05 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

Prostatic hypertrophy.

(duration) yrs. 8 mos. [illegible] ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 18 hrs.

18 Where was disease contracted if not at place of death? [illegible] Cleveland, Ohio

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood urea & physical exam.

(Signed) H Bailey, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wellington Ohio

DATE OF BURIAL Jan 12 1921

20 UNDERTAKER W M Rowson

ADDRESS Bruce Sanatoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho — Uremia due to Prostatic Hypertrophy

Spec.—6-9-19—H. P. Co.—1000 Bks.

049766

HEALTH DEPARTMENT—CITY OF BALTIMORE

049766

CERTIFICATE OF DEATH.

5 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N Eden ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Westkamp

(a) RESIDENCE. NO. 20 N Eden ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Westkamp

6 DATE OF BIRTH (month, day, and year) 8/14/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James McPhillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McPhillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James F. Westkamp
(Address) 20 N Eden St

15 Date JAN 12 1921 ROBERT F KRUGER Registrar Burial Permit 01662

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 – 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10 –, 1920, to Jan. 11, 1921, that I last saw her alive on January 10, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease, contracted kidney

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) – yrs. – mos. 5 ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests

(Signed) Edwin B. Fenby, M. D.

1/12/1921 (Address) 1223 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 15 1921

20 UNDERTAKER Jos. J. Herr ADDRESS 156 N. Luzerne ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1049767

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 217 W. Henrietta ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. Staten

(a) RESIDENCE. NO. 217 W. Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb, 22, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (G)

(b) General nature of industry, business, or establishment in which employed (or employer) Driving and

(c) Name of employer at wharves

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Staten

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Garrison

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Emma Staten
(Address) 217 W. Henrietta

15 Filed JAN 12 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 4, 1921, to Jan, 10, 1921, that I last saw h[illegible] alive on Jan 10, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar
Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Davis Donaldson, M. D.

1/11, 19 (Address) 1212 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 13 1921
20 UNDERTAKER	ADDRESS
John H. Loader	1412 W Fred St

mation should be carefully supplied. Any [illegible] may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L49768

HEALTH DEPARTMENT—CITY OF BALTIMORE

L49768

91-056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Sabins

(a) RESIDENCE. NO. 912 S. Chas. St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. Sabins

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer) Rh

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records (Address)

15 Filed JAN 12 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Jan 9, 1921, that I last saw her alive on Jan 9, 1921, and that death occurred, on the date stated above, at 2:20 P.m.

The CAUSE OF DEATH* was as follows:

Alcoholic delirium & Toxic Psychosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Data

(Signed) H. S. C. Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Jan 14 1921
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	417-3rd E Cage

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D4969

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D49769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 126 N. Cins ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Tilly

(a) RESIDENCE. NO. 126 N Cins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 23-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	—		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer (Genl)

(c) Name of employer Fells Pan Co

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER — John Tilly

11 BIRTHPLACE OF FATHER (city or town) Wallenville N.J.
(State or country)

12 MAIDEN NAME OF MOTHER — Mary Fortner

13 BIRTHPLACE OF MOTHER (city or town) Cheanpeake City
(State or country) Md

14 Informant Mrs Tilly
(Address) 202 Grundel St

15 Filed. JAN 12 1921 BURIAL PERMIT CLERK
Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan — 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to Jan 11, 1921, that I last saw h[illegible] alive on Jan 11, 1921, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D

Jan 11, 1921 (Address) 12-14 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1/13 1921
20 UNDERTAKER	ADDRESS
Michael Doyle	15 E Lee

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49770

CERTIFICATE OF DEATH.

92 D 49770

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 926 Hillman ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Jones

(a) RESIDENCE. No. 926 Hillman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown 1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Maryland Car Co

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Addie Evans

(Address) 926 Hillman ST

15 Filed JAN 12 1921, 19.. ROBERT L. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to Jan 10, 1921, that I last saw him alive on Jan 10, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. L. Hornstein, M. D.

1/11, 1921 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan 13 1920
20 UNDERTAKER John W Henderson	ADDRESS 1802 E Monument

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49771

114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary. 8

CITY OF BALTIMORE: (No. 26 N. Broadway. ST.; ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Jeasell
Samuel Ready School

(a) RESIDENCE. NO. North 2a Stanford Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED 068
(a) Trade, profession or particular kind of work Teacher - Primary
(b) General nature of industry, business, or establishment in which employed (or employer) Ready School.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland.

PARENTS
10 NAME OF FATHER Jacob Yeakle.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.
12 MAIDEN NAME OF MOTHER Sarah A. E. Galezio
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant James R. Yeakle
(Address) 8708 Forest Park Ave.

15 Filed JAN 12 1921 ROBERT N. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1920, to Jan 10, 1921, that I last saw her alive on Jan 10, 1921, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Stomach
Acute dilatation of heart.

(duration) yrs. mos. 1/2 hr. dy.

CONTRIBUTORY (Secondary) Cholelithiasis Ed
Cholelithiasis (duration) yrs. mos. 19+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 22-20

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + Autopsy

(Signed) Richard S. Coblentz, M. D

, 19 (Address) Church Home + Infm.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery Frederick Md	Jan 13, 1921
20 UNDERTAKER George F. Smith	ADDRESS 1060 W Fayette St

Information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. OCCUPATION is very important.

D49772

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D49772

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1528 Madison Ave ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles J Taylor.

(Residence in Baltimore: No. 1528 Madison Ave St.; 67 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M.	W.	Married

6 DATE OF BIRTH March 8, 1853 (Month) (Day) (Year)

7 AGE 67 yrs. ... mos. ... ds. | If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

9 BIRTHPLACE (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Jacob H Taylor

11 BIRTHPLACE OF FATHER (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Mary Chandler

13 BIRTHPLACE OF MOTHER (State or country) Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary H. Taylor

(Address) 1528 Madison Ave

JAN 12 1921 Filed ... 191

ROBERT P. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 1915, to Jan 10th 1921, that I saw him alive on Jan 10th 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis + Myocarditis

(Duration) Many yrs. ... mos. ... ds

Contributory (SECONDARY) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) E Ramp M. D.

Jan 11, 1921 (Address) 1733 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL Green Mount Cem. | DATE OF BURIAL Jan 13, 1921

20 UNDERTAKER Geo J Burk | ADDRESS Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D49773 HEALTH DEPARTMENT—CITY OF BALTIMORE D49773

CERTIFICATE OF DEATH.

91-056

1-PLACE OF DEATH Johns Hopkins Hospital Phipps clinic REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elwood M. Horn

(Residence in Baltimore: No. 802 N. Calhoun st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Feb. (Month) 28 (Day), 1880. (Year)

7-AGE, 40 yrs. 10 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... painter
(b) General nature of industry, business, or establishment in which employed (or employer) ..... painting

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, Elwood Horn

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Eastburn

13-BIRTHPLACE OF MOTHER (State or Country), Eastburn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie B. Hohman

(Address) Johns Hopkins Hosp.

15- JAN 12 1921 Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 11th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 11 1921, that I saw h.im alive on Jan 11 1921, and that death occurred, on the date stated above, at 3.55 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

..... (Duration) 22 yrs. ..... mos. ..... ds.

(Signed) Leslie B. Hohman M. D.

....., 191... (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 40 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Balt. Md

Former or usual residence 802 N. Calhoun St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lauden Park	Jan 12, 1921.

20-UNDERTAKER	ADDRESS
M Raby & Sons	1827 W. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D49774

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

152 D49774

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 526 N. Curley St. ST. 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yarnall Tarr.

(Residence in Baltimore: No. 526 N. Curley St. St.; yrs. mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Mfant.

6 DATE OF BIRTH: December 24, 1920 (Month) (Day) (Year)

7 AGE: ..... yrs. ..... mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Mfant. 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Yarnall Tarr.

11 BIRTHPLACE OF FATHER (State or country): St. Michaels, Md.

12 MAIDEN NAME OF MOTHER: Mary Alice Wilde

13 BIRTHPLACE OF MOTHER (State or country): Upland, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Wilde Tarr.

(Address) 526 N. Curley St.

Filed JAN 12 1921, 191 ROBERT B. BEAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 12, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 11, 1921, to Jan. 12 1921 that I saw h[illegible] alive on Jan. 11-21. 191 . and that death occurred, on the date stated above, at 2 9 - m.

The CAUSE OF DEATH* was as follows:

a Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen C Burtham M. D.

1-12-21, 191 (Address) 3139 E. Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Michaels Md

DATE OF BURIAL: 1-12, 1921

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E. Balto St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049775 – HEALTH DEPARTMENT—CITY OF BALTIMORE – 049775

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4316 Belvieu Ave ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Konitzky

(Residence in Baltimore: No. 4316 Belvieu Ave St. 18 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 16 (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. 3 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Marine Architect

9-BIRTHPLACE, (State or Country), Bremen Germany

PARENTS.

10-NAME OF FATHER, Frederick Konitzky.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Johanna H. Hamsen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Konitzky

(Address) 4316 Belvieu Ave

15- JAN 12 1921 Filed....., 191.....

ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1920, to January 11 1921, that I saw h.... alive on January 10 1921, and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt F Hardesty M. D.

1-11, 1921 (Address) State City.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem't — DATE OF BURIAL, Jan 13 1921

20-UNDERTAKER Bertram B Gore — ADDRESS 1723 N Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049776 HEALTH DEPARTMENT—CITY OF BALTIMORE 049776

CERTIFICATE OF DEATH. 28

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospit ST. 20 WARD)

2-FULL NAME George Saul

(a) RESIDENCE. NO. 30 W. Bentalou St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Saul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M. C. H.

15 JAN 12 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to Jan. 12, 1921, that I last saw him alive on Jan. 11, 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Rigney, M. D.

1-12-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem.	1/13/21
20 UNDERTAKER P. J. Fahey & Sons	ADDRESS 1318 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49777 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49777

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 421 Glen Edwards Ave WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philumenia Beluscia

(a) RESIDENCE. No. 421 Glen Edwards Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Nicholas Beluscia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank N. Beluscia

(Address) 421 Glenedward Ave

15 Filed JAN 12 1921 R.O.D. 19 [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1921, to Jan 11th, 1921, that I last saw h.. alive on Jan 10th, 1921, and that death occurred, on the date stated above, at 1240P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E Cross, M. D.

, 19 (Address) 2409 Mid. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Jan 13 1921

20 UNDERTAKER A E Marshall ADDRESS 3539 Fall Rd

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—8-24-14—M. & T.—2000 Bks.

D.49778 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2541 W. North Ave ST.; 15 WARD) REGISTERED No. C 1142

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Reitz

(Residence in Baltimore: No. 2541 W. North ave St.; 23 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. (Month) 21 (Day), 1842 (Year)

7-AGE, 78 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) 106

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs B. Reitz

(Address) 2541 W. North Ave

15- Filed JAN 12 1921, 191.... Robert P. Harrison, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 191.., to Jan 12 191.., that I saw him alive on Jan 11 191.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Hypostasis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western | DATE OF BURIAL, Jan 13, 1921

20-UNDERTAKER Geo. M. Zaeble | ADDRESS 23 E. Lemmon

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49779 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49779

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3110 Fredrick Av ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Edward Brecht

(a) RESIDENCE. NO. 3110 Frederick Av ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 56 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 21. 1841

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
79	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis E. Brecht
(Address) 3110 Fredk. Ave

15 Filed JAN 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1921 to Jan 11 1921, that I last saw h-i- alive on Jan 11 1921, and that death occurred, on the date stated above, at 2 P ... m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Degeneration
Valvular Heart Disease
(duration) Not Known yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Howard W. Jones M. D.

(Address) Jones Falls Sanitarium

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bretonsville Cemetery Rossville — DATE OF BURIAL Jan. 14 1921

20 UNDERTAKER C. W. Gill — ADDRESS 310 Fdk. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49780 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 25-91

CITY OF BALTIMORE (No. Spence St ST.; Morrell Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Rozgaitis

(a) RESIDENCE. No. Spence St ST.; Morrell Park WARD.
(Usual place of abode)

Length of residence in city or town where death occurred lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: -

6 DATE OF BIRTH (month, day, and year): Aug 7 1919

7 AGE — Years: 1 Months: 5 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NO NE

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Karl Rozgaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania Russia

12 MAIDEN NAME OF MOTHER: Rizaita

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania Russia

14 Informant (Address): Karl Rozgaitis Morrell Park

15 Filed JAN 12 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 12 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Jan 12 1921; that I last saw him alive on Jan. 11 1921 and that death occurred, on the date stated above, at 3 45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M C Fuhringer M.D.

1-12-19 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Jan 12 1921

20 UNDERTAKER: John Gubliauskas — ADDRESS: 725 S Pac

DATE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

D.49781 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Dead when arrived at Mercy St.; 16 WARD) REGISTERED No. C 1887

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Brooks

(Residence in Baltimore: No. 1127 N. Mount St.; yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, ..., 1884
(Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd jobs

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Perry

(Address) .....

15- Rec'd JAN 12 1921, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest Jan 4-1921, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in brain, (Laceration) Said to be homicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Riley M. D.
(Coroner.)

Jan 12, 1921 (Address) 1059 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan. 12 1921

20-UNDERTAKER David Eagler ADDRESS 916 E Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

D.49782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49782

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Lambert ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Green

(Residence in Baltimore: No. 540 Lambert St.; 15 yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 2, 1885
(Month) (Day) (Year)

7-AGE, 35 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS—

10-NAME OF FATHER, Archer Green

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Thomas

(Address) 540 Lambert

15-

JAN 12 1921

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Jan 10 1921, that I saw him alive on Jan 9 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. mos. ds.

(Signed) William E Burton M. D.

....., 191... (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Jan 12, 1921

20-UNDERTAKER David Evans

ADDRESS 916 Druid

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.49783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 29

CITY OF BALTIMORE (No. 1716 n Durham ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank H. Berkeley,

(Residence in Baltimore: No. 1716 n Durham St.; yrs., 57 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, April 12, 1864
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore,

PARENTS.

10-NAME OF FATHER, Wm. F. Berkley

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER, Mrs. Potts.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Pearl Wells.

(Address) 25 W Lexington St.

15- Filed JAN 12 1921, 191...

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. F. Kelly M. D.
(Coroner.)

, 191... (Address) 716 n Dur

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westminster	Jan 13, 1921
20-UNDERTAKER H. C. Brumbaugh & Son	ADDRESS Eldorado

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49784 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49784

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 McHenry ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Gosnell

(a) RESIDENCE. NO. 1504 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Luther Gosnell

6 DATE OF BIRTH (month, day, and year): Aug 7-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Aldridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Daniel Gillis
(Address) 1504 1/2 McHenry St

15 Filed ..... 19 ..... Robert P. Harrison Registrar
Burial Permit Clerk.

JAN 12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1920, to Nov 23, 1921, that I last saw h.r alive on Nov 22, 1920, and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Reed, M. D.

1-13-1921 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Md	1-13 1921
20 UNDERTAKER: William Cook	ADDRESS: 502 N Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRINT IN UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S

Spec.—8-24-14—M. & T.—2000 Bks.

D 49788 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 49788

87

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Archer ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Edward Williams

(Residence in Baltimore: No. 500 Archer St.: ....yrs.. 6 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, June 14, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Robert Edward Williams

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Virginia Lee

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Lee

(Address) 500 Archer St.

15- Filed JAN 13 1921, 191.... ROBERT B BRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 11, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 11 1921, that I saw h~~im~~ alive on Jan 10 1921, and that death occurred, on the date stated above, at 12¼ m.

The CAUSE OF DEATH* was as follows:

Malarial Hematuria

(Duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. L. Joslin M. D.

Jan. 11, 1921 (Address) 334 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn ct	Jan 13, 1921
20-UNDERTAKER	ADDRESS
L. L. Brown's Son	W. N. Mulberry-st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

049786

HEALTH DEPARTMENT—CITY OF BALTIMORE

049786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSPITAL #56

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. St.: 2d Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHAEL SULLIVAN.

(a) RESIDENCE. No. US. PUBLIC HEALTH SERVICE HOSPITAL #56 WARD. 35.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Annie Sullivan. 751 E Hilton st Philia Pa

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rambo Registrar.
(Address) FORT MCHenry Baltimore Md.

15 Filed JAN 13 1921 ROBERT S. FOSTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1920, to Jan. 12, 1921, that I last saw him alive on Jan. 12, 1921, and that death occurred, on the date stated above, at 8'55 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic Pulmonary Active.

Unknown (duration) -- yrs. ---- mos. ---- ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination.

(Signed) Thomas R. Payne, M. D.

1/12 1921 (Address) US. PHS. HOSP #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philia Pa	Jan 13 1921
20 UNDERTAKER S. Swinson & Bro	ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49787

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N Fulton Ave ST.; 15 WARD)

2-FULL NAME Anna M Buckingham

(a) RESIDENCE. NO. 1327 N Fulton Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life Time ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced (or) WIFE of Alfred Buckingham

6 DATE OF BIRTH (month, day, and year) Aug 30 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W. Waltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes P Ledley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Fannie Stehl

(Address) 1327 N Fulton Ave

15 Filed JAN 13 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Jan 11 1921, that I last saw her alive on Jan 11 1921, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Herbert E. Blake, M. D.

19 (Address) 1014 La Fayette.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reisterstown Fulhouse Cem	Jan 15 1921
20 UNDERTAKER	ADDRESS
William Cook	For E Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Blks.

049788 HEALTH DEPARTMENT—CITY OF BALTIMORE 049788

CERTIFICATE OF DEATH. 150

REGISTERED No. 1743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Hollins ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Frances Mattie Whelan

(a) RESIDENCE. No. 1023 Hollins ST., 18 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		21.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Paul Whelan

11 BIRTHPLACE OF FATHER (city or town) Chicago
(State or country)

12 MAIDEN NAME OF MOTHER Ann C. Behm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wyoming Co. Pa

14 Informant Wm P Whelan
(Address) 1023 Hollins Ave

15 Filed JAN 13 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/22/ 1920, to 1/12 1921, that I last saw h[illegible] alive on 1/12 1921, and that death occurred, on the date stated above, at 8 10 A m.

The CAUSE OF DEATH* was as follows:

Heart failure due to
general weakness.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Leo A. Behm, M. D.

19 (Address) 1023 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 13 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1005 N. Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0449789

HEALTH DEPARTMENT—CITY OF BALTIMORE

0449789

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 W. Fayette St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Wm E and Mary R Bell

(Residence in Baltimore: No. 2040 West Fayette St St.; ....yrs.,....mos.....ds.)

N.B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 12, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 1 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm E Bell

11-BIRTHPLACE OF FATHER (State or Country), Hillsdale Mich

12-MAIDEN NAME OF MOTHER Mary R Heng

13-BIRTHPLACE OF MOTHER (State or Country), Annapolis Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E Bell

(Address) 2040 W Fayette St

15- JAN 13 1921 Filed....., 191. ROBERT B BEAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1921, to Jan 12 1921, that I saw her alive on Jan 12 1921, and that death occurred, on the date stated above, at 9.15 m.

The CAUSE OF DEATH* was as follows:

Premature Birth 5½ mos

(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) Chas H Schaffer M. D.

Jan 12, 1921. (Address) 53 S Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Jan 14, 1921.

20-UNDERTAKER Jos. P. Cook — ADDRESS 1003 N Gay St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49790 HEALTH DEPARTMENT—CITY OF BALTIMORE D49790

CERTIFICATE OF DEATH. 157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Fleet ST.: V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson E. Stiles Jr.

(a) RESIDENCE. No. 1710 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30, 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Nelson Stiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bridgeton N. J.

12 MAIDEN NAME OF MOTHER Mary Hickey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Nelson Stiles (Address) 1710 Fleet St.

15 Filed JAN 13 1921 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Jan 11, 1921, that I last saw h— alive on Jan 10, 1921, and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Prolonged Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw Truman, M. D.

1/11, 1921 (Address) 517 Cath St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 13 1921
20 UNDERTAKER	ADDRESS
H. Vander & Son	1710 Fleet St.

Spec.—6-3-19—H. P. Co.—1000 Bks.

049791 HEALTH DEPARTMENT—CITY OF BALTIMORE 049791

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH Severn Apt.

CITY OF BALTIMORE: (No Monument & Cathedral ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mead Pegram

(a) RESIDENCE. No Monument & Cathedral ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, ~~widowed~~ or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Married

6 DATE OF BIRTH (month, day, and year) Sept 19th 1836

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	3	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Wm S Pegram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Lucy Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant F. E. Pegram
(Address) 940 Equitable Bldg

15 Filed JAN 13 1921 19 ROBERT J. BREUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Jan 12, 1921, that I last saw him alive on Jan 12, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: Arterio sclerosis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1/13, 1921 (Address) 1027 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 14 1921
20 UNDERTAKER Henry W Jenkins & Son Co	ADDRESS Cathedral & Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D49792 HEALTH DEPARTMENT—CITY OF BALTIMORE D49792

CERTIFICATE OF DEATH. 53

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 223 W. Monument St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Adelaide Hyde

(Residence in Baltimore: No. 223 W. Monument St.; 10 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. THIS IS A PERMANENT RECORD. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, August (Month) 22nd (Day), 1833 (Year)

7-AGE, 87 yrs. 4 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER, Joseph Bird

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia, Pa

12-MAIDEN NAME OF MOTHER Elizabeth M. Hyde

13-BIRTHPLACE OF MOTHER (State or Country), Charlestown Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Pratt Hyde

(Address) 223 W. Monument St.

15-

Filed ....., 191.... ROBERT B. KRAUTER

JAN 13 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 12th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11th 1921, to Jan 12th 1921, that I saw her alive on Jan 12 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Myeloid leukaemia

(Duration) 5 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. J. Keller M. D.

Jan 17, 1921. (Address) 222 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Jan 14th, 1921

20-UNDERTAKER Henry H. Jenkins Sons ADDRESS McCulloh & Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049793 HEALTH DEPARTMENT—CITY OF BALTIMORE 049793

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 N Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A Godey

(a) RESIDENCE. No. 1704 N Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND ~~of~~ (or) ~~WIFE~~ of: Married

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 65 | Months: | Days: | If LESS than 1 day, ...hrs. or ....min.: Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: T. Godey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant (Address): T. K. Godey 1704 N Calvert St

15 Filed JAN 13 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Jan 12, 1921, that I last saw him alive on Jan 12, 1921, and that death occurred, on the date stated above, at 9 30 Am.

The CAUSE OF DEATH* was as follows:

Myocarditis mechanical manifestations

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Julius Friedenwald, M. D.

Jan 12 1921 (Address) 10 13 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 15 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons Co	Mc Collohs

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49794

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Poplar Grove St.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Weigel

(a) RESIDENCE. No. 1200 Poplar Grove St., 16 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 24 ds. How long in U. S., If of foreign birth? 62 yrs. 8 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christine Weigel

6 DATE OF BIRTH (month, day, and year) April 18-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith.

(c) Name of employer Balto. Enameling Novelty Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christian C. Weigel ? ?

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Germany

12 MAIDEN NAME OF MOTHER not known ? ?

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Germany

14 Informant Miss Naomi M. Weigel-(daughter)
(Address) 1200 Poplar Grove St

15 FILED JAN 13 1921 ROBERT J. KRAUTER Registrar
1200 N Payson
Burial Permit Clerk
Ex. Mellstad.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1921, to Jan 10th, 1921, that I last saw h[illegible] alive on Jan 10th, 1921, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) Benj. McCleary, M. D.

1/14/21 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 14 1921

UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

D49795 HEALTH DEPARTMENT—CITY OF BALTIMORE D49795

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Tudor Hall Apartments ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Adams

(Residence in Baltimore: No. Tudor Hall Apartments St.; 57 yrs., 2 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, October (Month) 13 (Day), 1863 (Year)

7-AGE, 57 yrs. 2 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Quincy Adams

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Elizabeth Morron

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sam'l Kraut (sister)

(Address) Tudor Hall Apts.

15- Filed JAN 13 1921, 191.... ROBERT F. KRAUTER Burial Permit ...Clock Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. Thompson Morgan M. D. (Coroner.)

Jan 13, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....0 yrs....0 mos....0 ds. In the State....0 yrs....0 mos....0 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, Jany 14th, 1920

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49796

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Maine ave ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Ridgely

(a) RESIDENCE. No. 4000 Maine Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Ridgely

6 DATE OF BIRTH (month, day, and year): Oct. 17. 1837

7 AGE — Years: 83 — Months: 2 — Days: 24 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md

PARENTS

10 NAME OF FATHER: James L. Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: James Ridgely (Address) 4500 Maine Ave.

15 FILED JAN 13 1921 ROBERT A. LEAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19 20, to June 11, 1921, that I last saw him alive on June 11, 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

uremia

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L Ridgely, M. D.

. 19 (Address) 4500 Maine Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount DATE OF BURIAL: June 13 1921

20 UNDERTAKER: John D. Mitchell ADDRESS: 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular. CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Vojik

1049797

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049797

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N Bunley ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Vojik

(Residence in Baltimore: No. 407 N. Eurley St.; 21 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Vojik

(Address) 407 N. Bunley St

15- JAN 13 1921 Burial Permit Clerk
Filed..... 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 11 1921, that I saw h[er] alive on Jan 11 1921, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Obstruction

..... (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

....., 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cat Lawn

DATE OF BURIAL, Jan 14, 1921

20-UNDERTAKER Frank Evachson

ADDRESS 1906 Carlton

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49798 — 154 — D49798

1-PLACE OF DEATH Baltimore, Md.

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1309 W Saratoga ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Kruger

(a) RESIDENCE. No. 1319 Saratoga St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John H. Kruger

6 DATE OF BIRTH (month, day, and year) May 7 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John K. Krüger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Suzanna Kwiatoski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant N S Fine

(Address) 1835 W Pratt St

15 Filed JAN 13 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Jan 12, 1921, that I last saw h.r alive on Jan 10th, 1921, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ed Kuester

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo H Brantzen, M. D.

, 19 (Address) 204 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 15 21 19

20 UNDERTAKER MRS. N. S. FINE, ADDRESS
FUNERAL DIRECTORS
1835 W. PRATT STREET.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47799

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D47799

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Jud General Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Brown

(Residence in Baltimore: No. 1121 argyle ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1871 (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocery 034
(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore St

15- Filed JAN 13 1921, 191.....

ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis due to perforating of intestine as a result of gunshot wounds of abdomen Homicidal (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 11, 1921 (Address) 202 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Jud. Gen. Hosp. In the of death.....yrs.....mos. 2 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
1121 Argyle Ave

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodeph Sha | DATE OF BURIAL, Jan. 13, 1921

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

L49800

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 49800

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital, WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) RESIDENCE. No. 1328 Penn. ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Abram Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 13 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to Jan. 11, 1921

that I last saw h. im alive on Jan. 11, 1921

and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) J. Rigney, M. D.

1-11-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont Auburn	Jan 14 1921
20 UNDERTAKER John H Owens	ADDRESS 538 Dolphin

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49801

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Shorter

(a) RESIDENCE. No. 327 Freemont ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 1 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dakota

14 Informant Hospital Records

(Address) M. T. H.

JAN 13 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1921, to Jan. 11, 1921, that I last saw h.. alive on Jan. 11, 1921, and that death occurred, on the date stated above, at 4.35 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. H. Fahnestock. M. D.

1-11-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn	1/16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Monument

A. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

49802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D49802

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 N Fairmal ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M Ellen Shackelford

(Residence in Baltimore: No. 1634 N Fairmale St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Sept (Month) 22 (Day), 1843 (Year)

7-AGE	If LESS than 1 day,
77 yrs. 3 mos. 19 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Wm Medlicott

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER E Bridge

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marian V Shackelford

(Address) 1634 N Fairmale

15- JAN 13 1921

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 4 1919, to Jan 12 1921, that I saw h[er] alive on Jan 11 1921, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

..... Uremia Myocarditis .....

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis + arteriosclerosis (Duration) 6 or 7 yrs. ..... mos. ..... ds.

(Signed) M Bowman Hood M. D.

Jan 12, 1921 (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Jan 14, 1921
20-UNDERTAKER	ADDRESS
N M Routzon	2238 N Milton Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49863 ~~D49863~~ 137 D49803

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Mitchell

(a) RESIDENCE. No. 54 Orleans St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph W. Mitchell

6 DATE OF BIRTH (month, day, and year) Sept 11- 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. E. Reeves
(Address)

15 JAN 13 1921
Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to Jan 10, 1921, that I last saw h.e alive on Jan 10, 1921, and that death occurred, on the date stated above, at 11 25 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, General, Pyo Salpinx, left

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 8th '21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Roger S. Doughty M. D.

1-11, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Jan 13 1921
20 UNDERTAKER	ADDRESS 378 W Saddle
Samuel L Hemsley	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D49804 Kemp D49804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4717 Hartford Rd ST. 24 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Robert M Kemp

(Residence in Baltimore: No. 4717 Hartford Rd St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ... (Month) 1 (Day) ..... (Year)

7-AGE, about 72 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Obadiah Kemp

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm Lleems

(Address) 1321 N. Bond

15-JAN 13 1921 ROBERT J. KRAUTER

Filed....., 191..... Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Illuminating Gas Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Gundry M. D.
(Coroner)

1-11-, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, St Johns Cem — DATE OF BURIAL, Jan 13, 1921

20-UNDERTAKER Wm J Pickerston — ADDRESS North Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Gatt

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1449805 ~~Gatt~~ 1449805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Eutaw ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George R. Gatt

(Residence in Baltimore: No. 1626 Eutaw Place. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	married

6-DATE OF BIRTH, Feb 10 1858, 1 (Month) (Day) (Year)

7-AGE, 62 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lawyer 042
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Montgomery Co Md.

PARENTS.

10-NAME OF FATHER, Benjamin Gatt

11-BIRTHPLACE OF FATHER (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER Susan Darby

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Gatt

(Address) 1626 Eutaw Place

15- Filed JAN 13 1921, 191 ROBERT B. KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 11 1921, that I saw him alive on Jan 11 1921, and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

(Ulcers of Stomach.)

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (Hemorrhage Bowel)

(Duration) yrs. mos. 7 ds.

(Signed) D. A. C. Hansmann M. D.

Jan 11, 1921. (Address) 1203 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem — DATE OF BURIAL, Jan 13 1921.

20-UNDERTAKER Wm Tucker & Sons — ADDRESS North & Pc

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks: Probably Cancer

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49806 HEALTH DEPARTMENT—CITY OF BALTIMORE D49806

CERTIFICATE OF DEATH. -42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St.: 15 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Moran

(a) RESIDENCE. No. 2036 N. Fulton St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Moran

6 DATE OF BIRTH (month, day, and year) Unknown 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Whuppermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wyhman

12 MAIDEN NAME OF MOTHER Whuppermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Whuppermann

14 Informant Martha Passaway

(Address) 2036 N Fulton Ave

15 Filed JAN 13 1921 ROBERT A KRAJIER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to Jan 12, 1921, that I last saw h.. alive on Jan. 12, 1921, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

General carcinomatosis

(Papillo cystoma Ovary)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan 7, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical -

(Signed) Howard B. McClean M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elko Cemetery Md. Balto Co

DATE OF BURIAL Jan 16 1921

20 UNDERTAKER W. J. Tschudi & Son

ADDRESS Bath Ave

NOTICE TO PHYSICIANS, UNDERTAKERS AND THE INFORMANT. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49807

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1010 S. Bouldin ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Cannon, Ja.

(a) RESIDENCE. No. 1010 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 8- 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Md

PARENTS

10 NAME OF FATHER Saml E. Cannon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Alva Geoghegan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Saml E. Cannon
(Address) 1010 S. Bouldin St

15 Filed ....., 19..... ROBERT E. KRAUTER Registrar

JAN 13 1921 Bd. of Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/7/20, 19 20, to 1/12, 19 21,

that I last saw him alive on 1/12, 19 21,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

1 B Broncho pneumonia

(duration) Abt 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum Exam Positive

(Signed) L. S. Kachuster, M. D.

1/13, 1921 (Address) 2035 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Jan 15 1921
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1739 E. Eager

N. B.—WRITE PLAINLY. ALL INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D49808

110 D49808

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Guilford Ave & 21st. St.

REGISTERED NO.

CITY OF BALTIMORE: (No. Home for Incurables ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Cox

(a) RESIDENCE. No. 3611 Cedar Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Cox

6 DATE OF BIRTH (month, day, and year): Sept 11-1877

7 AGE — Years: 43 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Thomas N. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co Md

12 MAIDEN NAME OF MOTHER: Sarah Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs. Sarah E. Miller 3611 Cedar Ave

15 Filed JAN 13 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 10, 1921, that I last saw h alive on Jan 10 1921, and that death occurred, on the date stated above, at 8 9. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.
Uremia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary): Perirectal abscess.

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm S Gaye M. D.

. 19 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loch Spring Cemetery Forest Hill, Harford Co. Md

DATE OF BURIAL: Jan. 14 1921

20 UNDERTAKER: Horace Burgee & Son

ADDRESS: 3631 Gallo Rd.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49809

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3629 Hickory Ave. ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Shaffer

(a) RESIDENCE. NO. 3629 Hickory Ave. ST., 13 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 72 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Shaffer

(Address) 3629 Hickory Ave.

15 Filed JAN 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 2, 1920, to Jan 12, 1921, that I last saw her alive on Jan 12, 1921, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chron Inter Nephritis and Cer. Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Broomdreed M. D.

1/13, 1921 (Address) 846 E 36 St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Jan. 14 1921
20 UNDERTAKER Horace Burgee & Son	ADDRESS 3631 Falls Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Dolmer

D49810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49810

CERTIFICATE OF DEATH.

91-052

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Delmore

(Residence in Baltimore: No. #1402 Green St. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, (MARRIED), WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 9, 1888
(Month) (Day) (Year)

7-AGE 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Chas M. Gabriel

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Anna E. Metzger

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. M. Gabriel

(Address) Lancaster Pa.

15- Filed JAN 13 1921 191

ROBERT E KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Jan 12 1921
that I saw h[illegible] alive on Jan 12 1921
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Morphine Poisoning (Addict)

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

(Signed) W. Deed M. D.

Jan 12 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Columbia Pa

DATE OF BURIAL, Jan 12, 1921

20-UNDERTAKER Harry H. Witzke

ADDRESS 153 W Lemon St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0 49811

HEALTH DEPARTMENT—CITY OF BALTIMORE

0 49811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Johnson

(a) RESIDENCE. No. 621 W. Biddle st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER George Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records
(Address) M. T. H.

15 JAN 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to Jan. 11, 1921, that I last saw her alive on Jan. 11, 1921, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) L. H. Fahndrich, M. D.

1-12-20, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millington Kent Co. Md	Jan 14 1921

20 UNDERTAKER: A. M. Brown's Son (P. R. R. route) ADDRESS: 108 W. Monroe St

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form. 6-9-19—H. P. Co.—1000 Blks.

D49812 HEALTH DEPARTMENT—CITY OF BALTIMORE D49812

62

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 Haw ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lennox

(a) RESIDENCE. NO. 647 Haw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chambermaid

(b) General nature of Industry, business, or establishment in which employed (or employer) Steamboat

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Travers

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Isabella Harper

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Dave Clarkson
(Address) 647 Haw

15 Filed JAN 13 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Jan 12, 1921, that I last saw her alive on Jan 11, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
(duration) yrs. 6-8 mos. ds.

CONTRIBUTORY (Secondary) Tabes Dorsalis
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. S. McCard, M. D.

1/13, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ct.

DATE OF BURIAL Jan. 15 1921

20 UNDERTAKER Isaiah S. Bruce & Son.

ADDRESS 108 Mont

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49813

50-092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. H 110 W. Lexington St.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Housand

(a) RESIDENCE. NO. H 110 W. Lexington ST.. 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Mary M. Housand

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Levin Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Mary M. Housand

(Address) H 110 W. Lexington St

15 JAN 13 1921 REGISTERED Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1921, to Jan 9th, 1921,

that I last saw her alive on Jan 9th, 1921,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Orthritis

(duration) Intermm yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Frank N. Brown, M. D.

Jan 13 1921 (Address) 1223 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	January 1921
20 UNDERTAKER	ADDRESS
Wm. E. Evans & Son	1428 N Charles

18

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0449814 HEALTH DEPARTMENT—CITY OF BALTIMORE 0449814

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 635 n Lakewood St. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret J League

(Residence in Baltimore: No. 635 n Lakewood St.; yrs., 8 mos. 20 ds.)

54

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, April 21, 1866
(Month) (Day) (Year)

7-AGE. 54 yrs. 8 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....mIn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel Schaen

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Mara

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. League

(Address) 636 N. Lakewood

15-
Filed JAN 13 1921 191... ROBERT E KRAUTER
Registrar.
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knox Carter M. D.
(Coroner)

1-14-21, 191... (Address) 9 E. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Jan 14 1921

20-UNDERTAKER F. A. Krause & Son ADDRESS 743 Hanover St.

Turnbull

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

0449815 ✓ 84 0449815

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cedar Croft Road; Govans ST.) 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Rutherford Turnbull

(Residence in Baltimore: No. Cedar Croft Road, Govans. St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: Aug. (Month) 9 (Day) 1872 (Year)

7-AGE: 48 yrs. 5 mos. 2 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Internal Revenue Service
(b) General nature of industry, business, or establishment in which employed (or employer): Inspector Div. 4 08

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Henry C. Turnbull

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Ellen Rutherford

13-BIRTHPLACE OF MOTHER (State or country): Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elisabeth R. Turnbull

(Address) Govans Md.

15. Filed JAN 13 1921, 19.... ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 11th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to, Jan 11th 1921, that I saw h~~e~~ alive on Jan. 11 1921, and that death occurred, on the date stated above, at 2.9 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis, and
Acute Myocarditis

(Duration) — yrs. — mos. 7 ds.

Contributory (SECONDARY) Acute Dilitation of Heart

(Duration) — yrs. — mos. 3 ds.

(Signed), J. Topsley Green M. D.

Jan. 12, 1921. [Address] London Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Prospect Hill Towson — DATE OF BURIAL: Jany 13, 191...

20-UNDERTAKER: Henry W. Justice & Sons Co — ADDRESS: W. Fallsway & Orchard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Jerome Murphy

D49816 HEALTH DEPARTMENT—CITY OF BALTIMORE D49816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Preston Maryland Av. ST. pronounced dead at mercy Hosp. 9 WARD) 81

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Murphy

(Residence in Baltimore: No. 1906 Eastern Ave. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Engineman
(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, T. Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Sullivan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. M. Fenton

(Address) 700 E Chase

15 JAN 13 1921 Filed....., 191.... ROBERT J KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy of inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

..... Duration..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.
(Coroner.)

Jan 13, 1921 (Address) 16 39 Bussard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Jan 15., 1921
20-UNDERTAKER	ADDRESS
H C Kuduld	911 Fremont Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D49817 HEALTH DEPARTMENT--CITY OF BALTIMORE D49817

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1746 Park Ave ST. 14 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME J. Allen Moore

(Residence in Baltimore: No. 1746 Park Av St.; 10 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Ma

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) 2 (Day), 1850 (Year)

7 AGE: 70 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Baltimor City

PARENTS

10 NAME OF FATHER: Geo C Moore

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Allen

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. K. Parrish

(Address) 2201 St Paul St

15 Filed JAN 13 1921, 191 ROBERT I KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 11 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th, 1920, to Jan 17th 1921, that I saw him alive on Jan 17th, 1921, and that death occurred, on the date stated above, at 930 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with Valvular Lesion

(Duration) 20 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Deconpensation

(Duration) ? yrs. ..... mos. 20 ds.

(Signed) Dr William J Mossick M. D.

Jan 13th, 1920 (Address) 1700 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greensboro Md — DATE OF BURIAL: Jan 14, 1921

20 UNDERTAKER: Geo J Smith — ADDRESS: 1000 N Fayette St

Spec.—5-19-13—M. & T.—500 Bks.

Charles W Gardner

D49818

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D49818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 N. Bond ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Gardner.

(Residence in Baltimore: No. 1836 N. Bond St.; 5 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 21st, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Candy Manufacturer 045
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William N. Gardner.

11-BIRTHPLACE OF FATHER (State or Country). Balto. Co. Md

12-MAIDEN NAME OF MOTHER Emma B. Humphrey

13-BIRTHPLACE OF MOTHER (State or Country). Balt. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Annie M. Gardner

(Address)...1836 N. Bond St

15- JAN 13 1921 ROBERT B BRAUER

Filed....., 191.. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 12th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9 a.m. Jan. 12th 1921, to 9 a.m. Jan 12th 1921, that I saw him alive on the above Jan. 12th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with left Hemiplegia one hour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilmer Brinton M. D.

Jan. 12th, 1921. (Address) 1 W. Cor. Carey St. Brinton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 10 yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Jan. 15, 1921
20-UNDERTAKER George J. Smith	ADDRESS 1000 Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D49819 HEALTH DEPARTMENT—CITY OF BALTIMORE D49819

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 662 N. Fayette ST.; 4 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Joseph Shanahan

(Residence in Baltimore: No. 662 N. Fayette St.; .....yrs.....mos.....da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W.	Single

6-DATE OF BIRTH, Oct 24, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 600

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank M. Shanahan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Marie Agnes Harty

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JAN 13 1921, 191... ROBERT J KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1921, to Jan 12 1921, that I saw h.... alive on Jan 12 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

..... Marasmus None

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration) .....yrs.....mos.....ds.

(Signed) Henry H Weinberg M. D.

Jan 12, 1921. (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITA... JAN 13 1921

Remarks

Due to nonassimilation of food. No symptoms of intestinal trouble

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Sue Griffith

Spec.—6-9-19—H. P. Co.—1000 Eks.

D49820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49820

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genral Hosp. ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sue Griffith

(a) RESIDENCE. NO. 5218 York Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J W Griffith

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE: Years 24 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Birmingham ala.

PARENTS

10 NAME OF FATHER: Stoltzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: J W Griffith

(Address): 5218 York Road

15 JAN 13 1921 ROBERT P KRAUTER Registrar

Burial Permit 01568

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to Jan 13, 1921, that I last saw h.E.V. alive on Jan 13, 1921, and that death occurred, on the date stated above, at 8-10 A. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal puncture

(Signed) C. Wilbur Stewart. M. D.

, 19 (Address) Md Genl Bap

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Birmingham Ala.

DATE OF BURIAL: Jan 13/21

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E. Baltimore.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49821 HEALTH DEPARTMENT—CITY OF BALTIMORE D49821

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 231 N. Rose ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Kiefner

(a) RESIDENCE. No. 231 N Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write~~ the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8 — 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Com. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles F. Kiefner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Charles F. Kiefner

(Address) 231 Rose St.

15 Filed JAN 13 1921 ROBERT N KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1921

17

I HEREBY CERTIFY, That I attended deceased from 1-2-21, 19..., to 1-13-21, 19..., that I last saw h.. alive on 1-12-21, 19..., and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Diphtheritic Endocarditis

(duration) ... yrs. ... mos. 1½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. Seymour, M. D.

1/13/20 19 (Address) 2528 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan 14 1921
20 UNDERTAKER	ADDRESS
Geo. C. Miller	2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 49822

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1832 E Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Lambrackt.

(a) RESIDENCE. NO. 1832 E Orleans. ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Lambrackt.

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1844.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	10	15.	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work At Home. 00

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bremen. Germany.

PARENTS

10 NAME OF FATHER Geo. Bennewitt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berman. Germany.

12 MAIDEN NAME OF MOTHER Margaret Wenneman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bremen Germany.

14 Informant Clara G. Lambrackt. (Address) 1532 E. Orleans St.

15 Filed ....., 19.... Robert P. Harrison, Registrar

JAN 13 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1921.

17 I HEREBY CERTIFY, That I attended deceased from August -, 1919, to Jan 12, 1921, that I last saw h-er alive on Jan 12, 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Embole - Cortiac Dis - Valvular
Atero - Calcerous Deg -

(duration) 3 - yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Usual

(Signed) Jno. A. Brannan, M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetary	Jan. 15 1921
20 UNDERTAKER L. Heemann.	ADDRESS 32 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49823

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2933 Presstman St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur George Forni

(Residence in Baltimore: No. 2933 Presstman St.; 24 yrs., -- mos., -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, February (Month) 22 (Day), 1894 (Year)

7-AGE, 26 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk-American
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Corp.

009

9-BIRTHPLACE, (State or Country), Buffalo, New York

PARENTS.

10-NAME OF FATHER, Baccio Forni

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Hilda Schaeffer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alice B. Forni

(Address) 2933 Presstman Street

15- Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JAN 13 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to Jan 11 1921, that I saw him alive on Jan 11 1921, and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) John S. Fretland M. D.

Jan 12, 1921 (Address) 1219 Hopkinson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	1/14, 1921
20-UNDERTAKER	**ADDRESS**
Henry W. Kears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49824 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49824

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Roland Avenue St.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Cathell Green

(a) RESIDENCE. NO. 28 Roland Avenue ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Brown Green

6 DATE OF BIRTH (month, day, and year): Aug 13 1873

7 AGE: 46 Years 4 Months Days

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: D.W. Cathell M.D.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Worcester Co Maryland

12 MAIDEN NAME OF MOTHER: Anna Cathell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. J. Riddell

(Address): 1133 N. Charles St

15 Robert T. Harrison, Registrar

JAN 13 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1919, to January 12th, 1921, that I last saw her alive on January 12, 1921, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Obliteration of Heart

Sequelæ of Granular Kidneys

(duration) 7 yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Etc

What test confirmed diagnosis? Clinical Observation

(Signed) D.W. Cathell M.D., M. D.

, 1921 (Address) Room 1202 Emerson Hotel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clarksburg N. J.

DATE OF BURIAL: 1/15 1921

20 UNDERTAKER: Chas F. Evans How

ADDRESS: 1180 Mt Royal ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Agabus Bowen)

Spec.—8-24-14—M. & T.—2000 Bks.

D.49825 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49825

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Rampart ST.; 24 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agabus H Bowen

(Residence in Baltimore: No. 127 Rumsden St. 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 12, 1842
(Month) (Day) (Year)

7-AGE, 78 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired Farmer

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, William Bowen

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Dorsey

(Address) 1292 Rumside m

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk.

JAN 13 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1920, to Jan 12 1921, that I saw h[illegible] alive on Jan 11 1921, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 3 mos. ds.

(Signed) J. F. Hawkins M. D.

1/12/21 (Address) 1 E Rumsden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Emanuel Chapel Calvert Co Md	Jan 17, 1921
20-UNDERTAKER	**ADDRESS**
E I Dunning & Son	1338 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Hartly Boyd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L49826 L49826

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Dolphin ST.; 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hartley Boyd

(Residence in Baltimore: No. 711 Dolphin St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb. 17th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thos. Boyd

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Sara Boyer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Boyd

(Address) 711 Dolphin St.

15- Filed JAN 14 1921, 191.... ROBERT J. KRAUTER
Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 7th 1921, to Jan. 11th 1921, that I saw h.... alive on Jan. 11th 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) A. Lee Ellis M. D.

1/12, 1921 (Address) 722 N. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Jan. 14, 1921

20-UNDERTAKER Joseph A Farrell — ADDRESS 2319 Division

IMPORTANT: PHYSICIANS should state as nearly as possible the exact CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49827 HEALTH DEPARTMENT—CITY OF BALTIMORE D49827

CERTIFICATE OF DEATH. 40

REGISTERED No. 6424

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wright

(a) RESIDENCE. No. 2208 Hunter St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Isaac wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Abilla Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Sallie wright - Half sister (Address) 2208 Hunter St

15 Filed JAN 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1920, to Jan 13, 1921, that I last saw him alive on Jan 12, 1921, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. O. Ridgely, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cmtry	Jan 15 19
20 UNDERTAKER	ADDRESS 211 N Pine St
Mrs Chas B Jones	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 31

D49828

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Walsh

(a) RESIDENCE. No. 1429 Edmonson Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. X mos. ds.

South Carolina

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
6 Mo.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Do not know of

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hill S.C.
(State or country)

PARENTS

10 NAME OF FATHER John S. Walsh Do not know

11 BIRTHPLACE OF FATHER (city or town) Cincinnatti
(State or country) Ohio "

12 MAIDEN NAME OF MOTHER Ella Walsh

13 BIRTHPLACE OF MOTHER (city or town) Cincinnatti
(State or country) Ohio

14 Informant Mrs Ella Walsh.
(Address) 1429 Edmonson Ave

15 Filed JAN 14 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1921, to Jan. 12, 1921, that I last saw h.. alive on Jan. 12, 1921, and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis over

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. McCraig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	1-14 1921
20 UNDERTAKER H. C. Brauning & Son	ADDRESS 517 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049829 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital WARD 12)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fredericka Maurer

(a) RESIDENCE. No. 509 S. Fremont ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE~~ Ferdinand Maurer

6 DATE OF BIRTH (month, day, and year) May 15th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	8	~~2~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Friedrich Vollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredrika Vollmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Mrs Lena Michel

(Address) 42 Wilkins Av

15 Filed JAN 14 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9th, 1921, to Jan. 11th, 1921, that I last saw h[er] alive on Jan. 11th, 1921, and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Abdominal abscess which extended inwards from abscess of left inguinal gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Jan. 9th-21

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathology

(Signed) Philibert Artigiani, M. D.

19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 14 1921
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 N Rath

Spec.—8-24-14—M. & T.—2000 Bks.

Samuel Samorodin

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 49830 L 49830

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Bloom ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simcha Samorodin

(Residence in Baltimore: No. 510 Bloom St.: 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon M. Samorodin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Baltimore St

15- JAN 14 1921 ROBERT P KRAUTER

Filed ....., 191.... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1920, to January 14 1921, that I saw him alive on January 13 1921, and that death occurred, on the date stated above, at 5300 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) H. S. Hyman M. D.

1/14, 1921. (Address) 1515 N. Bentalou St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	1-14, 1921

20-UNDERTAKER	ADDRESS
Jack Levis	1411 E Baltimore St

Important. See instructions on back of certificate. Properly classified. Exact statement of OCCUPATION in plain terms, so that it may be

Spec.—8-24-14—M. & T.—2000 Bks.

Monosor

HEALTH DEPARTMENT—CITY OF BALTIMORE

049831 102 049831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. Monument ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Monosor

(Residence in Baltimore: No. 541 Brice St. St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, ... (Month) Unknown (Day) ..... (Year) 1898

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Monosor

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Esther Garbus

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balt St

15- JAN 14 1921 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4 1921, to Jan. 13 1921, that I saw him alive on Jan. 13 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer
(operation)
Peritonitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Edwin A. Levy M. D.

1-13..., 192.. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Workmen Circle

DATE OF BURIAL, 1-14, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D49832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49832

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2539 Pennsylvania Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dorsey Dowell

(Residence in Baltimore: No. 2539 Pennsylvania Ave St.: 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 22 (Month) (Day), 1875 (Year)

7-AGE, 45 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Swift & Co.

9-BIRTHPLACE, (State or Country), Calvert Co. Md

PARENTS.

10-NAME OF FATHER, Benjamin McDowell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Dowell

(Address) 2539 Pennsylvania Ave

15- JAN 14 1921 ROBERT I KRAUTER

Filed....., 191..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920, to Jany. 13, 1921, that I saw him alive on Jany. 12, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver probably involving pancreas & stomach

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice L. Shamer M. D.

Jany. 13, 1921. (Address) 3300 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 1/15/21

20-UNDERTAKER J. W. Bradley

ADDRESS Gilmor & Pitts Sts

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49833 HEALTH DEPARTMENT—CITY OF BALTIMORE D49833

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1600 Lorraine ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Jones

(a) RESIDENCE. No 1605 Lorraine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Jones

6 DATE OF BIRTH (month, day, and year) Sept 3 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer Wm J Buckler Jr 086

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nelson Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Mary Jones
(Address) 1600 Lorraine St

15 Filed JAN 14 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1920, to Jan 12, 1921, that I last saw him alive on Jan 8, 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Hypertrophy of Heart
(duration) ....yrs. 21 mos. ....ds.

CONTRIBUTORY (Secondary) ....
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Harry E Brown, M. D.

1/13 1921 (Address) 56 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem — DATE OF BURIAL Jan 15 1921

20 UNDERTAKER Wm J Tuckers Sons — ADDRESS Monument Sq

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49834

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 360 W Frederick Av ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Dobler Jr

(a) RESIDENCE. No. 360 W Frederick Ave ST.: 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 13 21

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Dobler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Drussel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Wm Dobler 360 W Frederick Ave

15 Filed JAN 14 1921 ROBERT I. KRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 14, 1921, that I last saw h... alive on Jan 13, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Premature Delivery at 7th Month.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

Jan. 15 (Address) Druid Lyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Jan 15 21
20 UNDERTAKER	ADDRESS
A B Kephart	2236 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D49835

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 102 E Belvedere Ave Ward) Walbrook

2-FULL NAME Willis L Boxtorer

(a) RESIDENCE. No. 102 E Belvedere Ave Ward. Arlington

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1910

7 AGE: Years 10 Months 6 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Norman H Boxtorer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Irene Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Norman H Boxtorer 102 E Belvedere Ave

15 Filed JAN 14 1921 19 ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch —, 19 18, to Jan 13, 19 21, that I last saw him alive on Jan 11, 19 21, and that death occurred, on the date stated above, at 3 25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Mitral Stenosis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Typical Sym

(Signed) Harding Bean, M. D.

1/13, 1921 (Address) 710 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	1/15 — 1920
20 UNDERTAKER	ADDRESS
Gilliam Cook	502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49836 HEALTH DEPARTMENT—CITY OF BALTIMORE D49836

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 Dolphin St. St.) (11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W. Parago

(a) RESIDENCE. No. 234 Dolphin St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schools

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wilson B Parago

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margarte [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wilson B. Parago
(Address) 234 Dolphin St

15 JAN 14 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1921, to Jan ; 1921, that I last saw h[illegible] alive on Jan 13, 1921, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart Chronic Nephritis

(duration) Since Jan 1920 yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

1-13, 1921 (Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 15 1921

20 UNDERTAKER	ADDRESS
Felix B Pyle	102 E Mulberry 102 E Hamilton

CAUSES OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

049837 HEALTH DEPARTMENT—CITY OF BALTIMORE 049837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 O. St. 2nd St. WARD) 21

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Indianna Carter

(Residence in Baltimore: No. 830 W O St 2nd St St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Blk	Married

6-DATE OF BIRTH, Unknown, 18..
(Month) (Day) (Year)

7-AGE. about 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 03

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wm Brooks

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nadie Park

(Address) 830 O St 2nd St

15. JAN 14 1921 Filed ....., 191... ROBERT J KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 10 1921, that I saw her alive on Jan 10th 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Abdominal Tumor over
Malignant (not Sarcoma)
said to be of several months
only seen by a week ago
(Duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Senility & heart failure
Pericarditis (Duration) yrs. mos. 6 ds.

(Signed) John H Mauger M. D.
Jan 13, 1921 (Address) 1002 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 14 ds. In the State yrs. mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Va

19-PLACE OF BURIAL OR REMOVAL, Hawkins Neg Cem Va — DATE OF BURIAL, Jan 16, 1921

20-UNDERTAKER, Bruce L Kennedy — ADDRESS 578 N Bridle

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

649838 HEALTH DEPARTMENT—CITY OF BALTIMORE 649838

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 407 N Gilmor ST.: 19 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Grimes

(Residence in Baltimore: No. 407 N Gilmor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. ..... Aug. (Month) 23., (Day) 1924 (Year)

7-AGE, ... yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None .....

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. Wm C Grimes

11-BIRTHPLACE OF FATHER (State or Country). Delaware

12-MAIDEN NAME OF MOTHER Lottie Chase

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Grimes

(Address) 407 N Gilmor

15- JAN 14 1921 ROBERT N KRAUTER

Filed ....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 12, 1924.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Chronic Congestion of Lungs .....
..... Jaundice Acute Endocarditis .....
.....
..... (Duration) .....yrs. .....mos. 3 ....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... James H. Hartman ..... M. D. (Coroner.)

Jan 13., 1924 (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	1/14/24 19....
20-UNDERTAKER Daniel Easton	ADDRESS 916 Penna Ave

D49839 HEALTH DEPARTMENT—CITY OF BALTIMORE D49839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1907 E. Fayette ST.: V WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert B Armiger

(Residence in Baltimore: No. 1907 E. Fayette St.; yrs., mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE carefully supplied. ACE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day), 1856 (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Second Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer in clothes

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, dont know

11-BIRTHPLACE OF FATHER (State or Country), Ind.

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Moran

(Address) 3002 E Baltimore

15- ROBERT F KRAUTER

Filed JAN 14 1921, 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hans Gasser M. D.
(Coroner)

June 8, 1921, (Address) City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lamel Cem, DATE OF BURIAL, 1-14, 1921

20-UNDERTAKER J. A. Moran ADDRESS 3002 E Baltimore St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49840 HEALTH DEPARTMENT—CITY OF BALTIMORE D49840

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1714 N. Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Shoemaker Rawlings

(a) RESIDENCE. No. 1714 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24" 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Adams Express Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George A. Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Almira F. Woodcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Flora Rawlings Cox
(Address) 1714 N. Broadway

15 Filed JAN 14 1921 ROBERT B. ARMSTEN Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12" 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1920, to Jan 12th, 1921, that I last saw him alive on Jan 12th, 1921, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Obvious Signs only.

(Signed) Lenard M. C. Parker, M. D.

Jan 13, 1921 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 14" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1005 N. Bathe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 49841 (49841)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Mrs. Matthews

(Residence in Baltimore: No. Augusta St & Ashland Ave St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 4 (Day), 1847 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 7 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Work
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Mathews

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Bernard

(Address) Notre Dame Augusta St

Filed JAN 14 1921, 191.. ROBERT J. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 10 1921, to January 12 1921, that I saw h.. alive on January 12 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Senile Dementia
Pellagra

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Kirby M. D.

January 13 1921 (Address) 1102 Dolphin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loch Raven Md.	January 15, 1921.
20-UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1049842

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049842

CERTIFICATE OF DEATH.

REGISTERED NO. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 E. Baltimore ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jefferson Smackum

(Residence in Baltimore: No. 207 E. Baltimore St. St.; 20 yrs., 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, Unknown, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): Taxi

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Edward Smackum

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Georganna Worden

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beulah Mosby

(Address) 5002 Druid Hill Ave

15- JAN 14 1921 ROBERT P KRAUTER

Filed ....., 191.... Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 11 1921, to January 13 1921, that I saw h[illegible] alive on January 11 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilat of Lungs

0000

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) H Stokes M. D.

January 15, 1921 (Address) 607 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, N. Eutaw Cem Balto Co. DATE OF BURIAL, Jan. 16, 1921

20-UNDERTAKER Sam'l N. Chase & Son ADDRESS 1400 Mosher

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D49843 HEALTH DEPARTMENT—CITY OF BALTIMORE D49843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fort Ave. & Decatur st. ST.: 3 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Griffith. (C). 80

(Residence in Baltimore: No. 31 E. Dallas Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, August 10th. 1873., 1
(Month) (Day) (Year)

7-AGE, 42 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. Old
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Smith. (C)

(Address) 31 E. Dallas Street.

15- Filed JAN 14 1921, 191. ROBERT F KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th, 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Jan. 13th, 1921. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	Jan 15, 1921
20-UNDERTAKER L. L. Brown & Son	ADDRESS 1911 Mary St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-24-19—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L049844 — 64 — L049844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Dawson St.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Belle Blue

(Residence in Baltimore: No. 1535 Dawson St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov 25, 1872 (Month) (Day) (Year)

7-AGE, 49 yrs. 2 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Dk

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Battle

11-BIRTHPLACE OF FATHER (State or Country), Dont-Know

12-MAIDEN NAME OF MOTHER Julia B. Battle

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva E Blue

(Address) 1535 Dawson St.

15- Filed JAN 14 1921, 191.... ROBERT B KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Jan 12 1921, that I saw h[er] alive on Jan 12 1921 and that death occurred, on the date stated above, at 9.14 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Daughtry M. D.

Jan 12, 1921. (Address) 1602 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, Jan 16 1921

20-UNDERTAKER George T. A. Gibson — ADDRESS 513 Fawn St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049845 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049845

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1343 N Strieker ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Shipley,

(a) RESIDENCE. No. 1343 N Strieker ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Ci	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate

6 DATE OF BIRTH (month, day, and year) Oct 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Joseph Shipley Baltimore City

PARENTS

10 NAME OF FATHER Joseph Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Bursk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Kate Shipley

(Address) 1343 Strieker

15 Filed JAN 14 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to Jan 11, 1921, that I last saw him alive on Jan 11, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia left lower lobe

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Agg. Arteriosclerosis

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wight M. D.

(Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Jan 14 1921

20 UNDERTAKER George H. Holland — ADDRESS 1631 Pleasant Hill Ave

that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

049846

HEALTH DEPARTMENT—CITY OF BALTIMORE

049846

CERTIFICATE OF DEATH.

53

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 N. Milton. Ave ST. 8 WARD)

2-FULL NAME Helen L. ~~Roth~~ Roll

(a) RESIDENCE. No. 1733 N. Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 3 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 30 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William Roll

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Stenger

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Mr. William Roll
(Address) 1733 N. Milton Ave.

15 Filed JAN 14 1921 BOBERT F. LEATHERS Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to JAN 13, 1921, that I last saw h[illegible] alive on JAN 13, 1921, and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia.

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? C.

Did an operation precede death? no Date of

Was there an autopsy? no. Only Microscopic Examination

What test confirmed diagnosis?

(Signed) Chas. L. Schwartz, M. D.

Jan. 19 21 (Address) 928 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 15 1921
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Do not use abbreviations. Be particular and write plainly.

Spec.—8-24-14—M. & T.—2000 Blks.

64 649847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 649847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 674 W Lexington ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mack

(Residence in Baltimore: No. 674 W Lexington St.; 20 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept 1, 1837
(Month) (Day) (Year)

7-AGE, 83 yrs. 4 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... ded

9-BIRTHPLACE, (State or Country) Chambersburg Pa.

PARENTS.

10-NAME OF FATHER, Simon M. Myers.

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Susan Coffenhagen

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon M. Hursh

(Address) 129 S. Bouldin St

15- Filed JAN 14 1921, 191.. ROBERT J. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Jan 13 1921, that I saw h[illegible] alive on Jan 13 1921, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Isabella E. Mussa M. D.

Jan 14, 1921. (Address) 520 Holland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lancaster Pa — DATE OF BURIAL, Jan 17, 1921

20-UNDERTAKER Mrs. Mrs J. W. Imfeld — ADDRESS 801 W Fayette

049848 HEALTH DEPARTMENT—CITY OF BALTIMORE 049848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 13 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hallie T. Pullen.

(Residence in Baltimore: No. 801 Wellington Street. St. 8 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single.

6-DATE OF BIRTH, June (Month) 17 (Day), 1893 (Year)

7-AGE, 27 yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Thomas G. Pullen.

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Martha L. Settles.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Johnson.

(Address) 506 N. Calvert St.

15- JAN 14 1921 Filed, 191 ROBERT J. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract base of skull (Caused by accidentally falling from ~~bed~~ Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Fuller M. D. (Coroner.)

Jan 14, 1921 (Address) 16th & Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Richmond Va

DATE OF BURIAL, Jan. 14, 1921

20-UNDERTAKER William Cook

ADDRESS 502 N. North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049849

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

28 1049849

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 510 Roschill Terrace ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Nevette Steele Williams

(a) RESIDENCE. NO. 510 Roschill Terrace. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lucie B. Williams.

6 DATE OF BIRTH (month, day, and year) Sept 28-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mc Clung Corp.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. T. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Antoinette Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila-Pa.

14 Informant Lucie R. Williams.
(Address) 570 Roschill Terrace.

15 Filed JAN 14 1921 ROBERT I. FRAZIER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 1918, to Jan 13, 1921, that I last saw h. alive on January 13, 1921, and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum examination

(Signed) Frank H. Bunn, M. D.

1/13. 1921 (Address) 243 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 17- 1921
20 UNDERTAKER William Cook.	ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

049850 HEALTH DEPARTMENT—CITY OF BALTIMORE 049850

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 162 n Hare St. ST.: 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Cuneo.

(Residence in Baltimore: No. 162 n. Hare St., S. 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 31, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 1 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Peanut Peddler
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Don't Know.

11-BIRTHPLACE OF FATHER (State or Country), Unt Kun

12-MAIDEN NAME OF MOTHER Unt Kun

13-BIRTHPLACE OF MOTHER (State or Country), Unt Kun

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L. Cuneo

(Address) 160 N. Hare St.

15-

Filed JAN 14 1921 by ROBERT J. KRAUTER

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry Finney M. D.
(Coroner.)

1-12, 1921 (Address) 711 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Jan. 15, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49851 HEALTH DEPARTMENT—CITY OF BALTIMORE D49851

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 W. Mulberry ST. 30 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Steinhauer

(a) RESIDENCE. No. 2115 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13, 1921

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work W. (Child)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William H. Steinhauer

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Allen

13 BIRTHPLACE OF MOTHER (city or town) Belair
(State or country)

14 Informant W. H. Steinhauer
(Address) 2115 W. Mulberry

15 Filed Jan 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 13, 1921, that I last saw her alive on Jan 13, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley Hoy, M. D.

1/14 1921 (Address) 296 Steinhauer Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Jan 15 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W. Fremont

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49852 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49852

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2204 Orleans St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Ennis.

(a) RESIDENCE. No. 2204 Orleans St., 6 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Ennis

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Policeman

(b) General nature of Industry, business, or establishment in which employed (or employer) Police Headquarters

(c) Name of employer

061

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Robert Ennis.

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mary Brawner

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Mary A. Ennis.
(Address) 2204 Orleans St.

15 Filed JAN 14 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920, to Jan. 12, 1921, that I last saw him alive on Jan. 12, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Trigeminal Neuralgia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Passagno, M. D

Jan. 13, 1921 (Address) 2314 E. Baltimore St—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 15th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeller	403 S. Wolfe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49853 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49853

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 N. Calvert St. ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Hyson

(a) RESIDENCE. NO. 2602 N. Calvert St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura T. Hyson.

6 DATE OF BIRTH (month, day, and year) July 28- 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor.

(b) General nature of industry, business, or establishment in which employed (or employer) Metal Lathing.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. S. Hyson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ketuaka Sater.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Laura T. Hyson.

(Address) 2602 N. Calvert St.

15 Filed Robert P. Harrison, Registrar

N 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 1921

16 DATE OF DEATH (month, day, and year) Jan. 14th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1920, to Jan. 13th, 1921, that I last saw him alive on Jan. 13th 1921 and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

& aboard

(duration) 8 or 9 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Acute Cardiac Neuralgia (duration) 8 hrs, mos. ds.

18 Where was disease contracted if not at place of death? Don't Know,

Did an operation precede death? No. Date of X

Was there an autopsy? No - Physical Exam,

What test confirmed diagnosis?

(Signed) Edward C. Price, M. D.

, 19 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Freelands Mt, Zion, M.E.Cem. Md.	1/17 1921

20 UNDERTAKER Chas E. Evans & Son ADDRESS 118 W. Mt. Royal ave

TION is very important. See instructions on back of certificates.

...may be properly classified. Exact st... ...ture of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49854 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49854

CERTIFICATE OF DEATH. X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Murphy

(a) RESIDENCE. NO. New Haven Conn. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Not Known abt 57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer) Made Hats

(c) Name of employer Don't Recall

9 BIRTHPLACE (city or town) (State or country) Probably New Haven Conn

PARENTS

10 NAME OF FATHER Jno Murphy

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) England

12 MAIDEN NAME OF MOTHER K. McGuggan

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 Filed JAN 14 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1920, to Jan 13th, 1921, that I last saw h[illegible] alive on Jan 13-, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis - With Cardiac Complications -

abt (duration) 3 or 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Intramural Dilatation - Post Mortem Depression Psychosis (duration) 3 or 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New Haven Conn

Did an operation precede death? N/A Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Jan 14, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Haven Conn. DATE OF BURIAL Jany 14 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

IMPORTANT is very important. See instructions on back of certificates. Exact state of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D.49855 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49855

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 E. Hillard ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Robinson

(Residence in Baltimore: No. 1029 E Hillard St. 45 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, (Month) (Day) 1849 (Year)

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver 173
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER — —

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Robinson

(Address) 1029 E Hillard ave

15-

Filed JAN 15 1921, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 10 1921, that I saw h[illegible] alive on Jan 12 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) C M Hosea M. D.

Jan 14, 1921 (Address) 714 S Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery — DATE OF BURIAL, Jan 16, 1921

20-UNDERTAKER John H Todd — ADDRESS 142 N Bond St

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49856 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49856

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 N Schroeder ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Meet

(a) RESIDENCE. NO. 236 N Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13-1921

7 AGE Years Months Days If LESS than 1 day, 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Meat

11 BIRTHPLACE OF FATHER (city or town) Crisfield (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Payne

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John Meat (Father)
(Address) 236 N Schroeder St

15 Filed JAN 15 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 14, 1921, that I last saw her alive on Jan 13, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Morris Legge, M. D.

1-14. 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	Jan 15 1921
20 UNDERTAKER	ADDRESS
John H Taddwin	142 N Hill St

...TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49857 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49857

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 E. Eager st. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Mueller.

(a) RESIDENCE. No. 1710 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21 - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended school.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore city
(State or country) Md.

PARENTS

10 NAME OF FATHER John Mueller.

11 BIRTHPLACE OF FATHER (city or town) Balto. city
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Strong.

13 BIRTHPLACE OF MOTHER (city or town) Balto. city
(State or country) Md.

14 Informant John Mueller.
(Address) 1710 E. Eager St.

15 Filed JAN 15 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 19 21

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3 — 19 20, to Jan 11 — 19 21, that I last saw h[illegible] alive on Jan 11 19 21, and that death occurred, on the date stated above, at 10.45 - 6 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 4+ mos. ds.

CONTRIBUTORY (Secondary) Diabetes Coma —

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? blood

(Signed) H. Perry Bonsall M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 15 1921
20 UNDERTAKER Lilly & Zeile.	ADDRESS 403 S. Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49858 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49858

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 859 W Lombard St. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward M. Niparawicz

(a) RESIDENCE. No. 859 W Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life Time mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of April 25. 1919

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE.

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stanislaw Niparawicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania Russia

12 MAIDEN NAME OF MOTHER Grogericz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) M Niparawicz 859 W Lombard St.

15 Filed JAN 15 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Jan 13, 1921, that I last saw him alive on Jan. 13, 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) NONE. (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) M.D. Finkinger MD

1-14-1921 (Address) 682 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 15 1921
20 UNDERTAKER	ADDRESS
John Grabliauckas	415 S. Paca St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49859

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Collington Ave. Ward 7)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Snyder

(a) RESIDENCE. No. 518 N. Collington Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Snyder

6 DATE OF BIRTH (month, day, and year) Mar 2-51

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Snyder 518 N. Collington Ave

15 Filed ..... 19..... Robert P. Harrison Registrar

N 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 12, 1921, that I last saw h.. alive on Jan 12, 1921, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

duration ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A B Lemmon M. D.

1/13 1921 (Address) 918 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 15 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

FOR IS very important. See instructions on back of certificates. Exact st... of OCCUPA-

Spec. 6-3-19—H. P. Co.—1000 Bks.

D.49860 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49860

CERTIFICATE OF DEATH.

H O

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3323 Edmondson Av. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Doenges

(a) RESIDENCE. No. 3323 Edmondson Av. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Chas. Doenges

6 DATE OF BIRTH (month, day, and year) Jan 7-57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mikman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Wm Brass

(Address) 3323 Edmondson Av

15 Filed JAN 15 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Jan 13, 1921, that I last saw h[er] alive on Jan 13, 1921, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction - cancer

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter Foster, M. D.

1/15, 1921 (Address) 3405 Gardenia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elder Hill	Jan 15 1921

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer probably originated in liver.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49861

CERTIFICATE OF DEATH.

137-091

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Randle

(Residence in Baltimore: No. 421 S. Vincent St.; 20 yrs., 4 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH. Aug (Month) 26 (Day) 1900 (Year)

7-AGE. 20 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework 037
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Gus Summers.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Lottie Everts

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. A. Randle

(Address) 421 S. Vincent St

15-

Filed....., 191.... Robert P. Harrison, Registrar.

N15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 13 1921, that I saw h[illegible] alive on Jan 13 1921, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

..... (Duration).....yrs.....mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration).....yrs.....mos. 5 ds.

(Signed) Geo. L. Wilson M. D.

Jan 13, 1921. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Am	1-15 ....., 191....
20-UNDERTAKER Robert Bookseem	ADDRESS CALHOUN HOLLINS ST

Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 N. Carolina St.; 5 WARD)

REGISTERED No. C 96

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME Annie M. Manogy

(Residence in Baltimore: No. 728 N. Carolina St. St.; 1 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ? ? 18??
(Month) (Day) (Year)

7-AGE 52 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dolan Wolford

(Address) 728 N. Carolina St.

15- Robert P. Harrison,

Filed JAN 15 1921, 191.... Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 04/12/1921, to 13 Jan, 1921, that I saw h[illegible] alive on 13/1/21, and that death occurred, on the date stated above, at 1.05 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis
asthma
Several years
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia acute
Tobacco (Duration) several hours yrs. mos. ds.

(Signed) Edmund P. Boyle M. D.

1/31/21, 192. (Address) 425 N. Carolina St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Jan. 16, 1921.
20-UNDERTAKER Joseph A Farrell	ADDRESS 1319 Division St

Fill out on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.49863 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49863

CERTIFICATE OF DEATH.

53

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Bittdorf

(Residence in Baltimore: No. 615 S Lakewood Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Mr 6, 1900 (Month) (Day) (Year)

7-AGE, 21 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grinder 023
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), U. S. A. Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Bittdorf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bell Sattler

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bittdorf

(Address) 615 S. Lakewood

15- JAN 15 1921 Robert P. Harrison, ..., 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31 1921, to Jan 13 1921, that I saw him alive on Jan. 13 1921, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(Duration) ..... yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benj Baehr M. D.

Jan. 13, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 35

Former or usual residence 332 S. Pulaski St.

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Jan. 15, 1921.

20-UNDERTAKER John Herwig & Co ADDRESS 2008 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49864 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49864

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. St.: 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Dettman

(a) RESIDENCE. NO. 2020 Clifton Ave St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank L. Dettman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Flora B. Shiver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Flora B. Shiver (Address) 2020 Clifton Ave.

15 Filed ....., 19 ..... Registrar

JN 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15- 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to Jan 14, 1921, that I last saw him alive on Jan 14, 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Status epilepticus

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 14, 1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H B McElwain, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL Jan 15- 1921

20 UNDERTAKER William Cook.

ADDRESS 502 E. North ave

Note is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49865 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49865

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Eutaw ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Douglass Warren

(Residence in Baltimore: No. 913 N. Eutaw St.; Lik yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Unknown ..... (Month) ..... (Day), 18[illegible] (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Oil

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Aidan Warren

11-BIRTHPLACE OF FATHER (State or Country). Ire

12-MAIDEN NAME OF MOTHER Lafania Turner

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary O. Warren

(Address) 913 N. Eutaw St.

15- Robert P. Harrison,

Filed....., 191.....

JAN 16 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan ..... (Month) ..... 13 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8th 1921, to Jan 13 1921, that I saw h[illegible] alive on Jan 13 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

..... (Duration) ..... yrs., ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) ..... M. D.

Jan ....., 1921 (Address) 712 S. Wood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Jan 16., 1921.

20-UNDERTAKER Samuel Hindley ADDRESS 1128 Eutaw

Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49866 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49866

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Ellwood Av ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Guy

(a) RESIDENCE. No. 305 N. Ellwood Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Henry Guy

6 DATE OF BIRTH (month, day, and year) May 6, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joshua Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rebecca Seggine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary V. King

(Address) 1535 N. Milton Ave

15 Filed ....., 19.. Robert P. Harrison, Registrar

NOV 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 9th, 1920, to Jan 13th, 1921, that I last saw h[illegible] alive on Jan 12th, 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Pelvic Tumor (Sarcoma Malignant)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 25/20 for all stones

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Reis, M. D.

Jan 15 1921 (Address) 24 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Jan 17 1921
20 UNDERTAKER Winkler & Winkler	ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.49867 ✓ D.49867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH
49867
CITY OF BALTIMORE: (No. 622 W Mulberry ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Williams

(Residence in Baltimore: No. 622 W Mulberry St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1861. (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph H. Williams

11-BIRTHPLACE OF FATHER (State or Country), Va "

12-MAIDEN NAME OF MOTHER Georgeline Biddy

13-BIRTHPLACE OF MOTHER (State or Country), Va "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Bailey

(Address) 726 N. Saratoga St.

15- Filed JAN 15 1921, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12 (Month) 12th (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 28th 1920, to Jan 12th 1921, that I saw h[illegible] alive on 11th Jan 1921, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Both Lungs (Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) yrs. mos. 10 ds.

(Signed) Frank Hyman M. D.

Jan 13, 191... (Address) 120 Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, Jan. 14, 1921.

20-UNDERTAKER James L. Heisley ADDRESS 778 W Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49868 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49868

84

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincents Infant Asylum ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cyril Hagerty

(a) RESIDENCE. No. 1401 Division St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Hagerty

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant E. W. Mauthe
(Address) St. Vincents Infant Asylum

15 Filed ..... 19 Robert P. Harrison, Registrar

N 15 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1921, to Jan. 14, 1921, that I last saw him alive on Jan 14, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas R Maurer M. D.

Jan 15, 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 17 1921

20 UNDERTAKER Martin Fahey ADDRESS 1827 W North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49869 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 McMechen ST., 1479 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Beck

(a) RESIDENCE. No. 209 McMechen ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John C Beck

6 DATE OF BIRTH (month, day, and year): Aug. 12/1850

7 AGE: Years 70 Months 5 Days 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cumberland Md

PARENTS

10 NAME OF FATHER: Jos H Neumyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Thayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. D. Lantz 209 McMechen

15 Filed JAN 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to Jan 14 1921, that I last saw her alive on Jan 14 1921, and that death occurred, on the date stated above, at 11 PM.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. B. Culbertson, M. D.

1/14 1921 (Address) 1800 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Jan 17 1921

20 UNDERTAKER: Wm Cook 502 E North Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.49870 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49870

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 W. Lombard ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May E. Abbott

(a) RESIDENCE. No. 1911 W. Lombard ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER David R. Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Josephine E. Hannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant David R. Abbott

(Address) 1911 W. Lombard St.

15 Filed JAN 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 18, 1921, to Jan 14, 1921, that I last saw her alive on Jan 14, 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Wilbur Fleming M. D.

Jan 17th 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 17th 1921
20 UNDERTAKER	ADDRESS
R. A. Hamm	3767 Reisterstown Rd

(See instructions on back of certificates. Name and address of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49871 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49871

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Born Alley ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally Stewart

(a) RESIDENCE. NO. 1401 Born Alley ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Moses Stwert

6 DATE OF BIRTH (month, day, and year) Unknown. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Took in wash. at home

(c) Name of employer Heself

9 BIRTHPLACE (city or town) (State or country) St. Mary s Co. Md.

PARENTS

10 NAME OF FATHER Thomas Woodland

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Jane Bennitt

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Co (State or country) Md.

14 Informant Moses Stwert (Husband)
(Address) 1401 Born Alley

15 Filed JAN 15 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-1921 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13th, 1921, to Jan. 14th, 1921, that I last saw her alive on Jan 13th, 1921, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Appolexy, Cerebral.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis. Emotion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter S. Jackson, M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan. 17th, 1921
20 UNDERTAKER Chas H Holland	ADDRESS 1231 Druid Hill Ave

IMPORTANT IS very important. See instructions on back of certificates. ...ing of property classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49872

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH (CITY OF BALTIMORE: (No. St. Agnes' Hospital ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret E. Severns

(a) RESIDENCE. No. 2510 Frederick Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not any

6 DATE OF BIRTH (month, day, and year) Nov 12 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. L. Severns

11 BIRTHPLACE OF FATHER (city or town) Sykesville
(State or country) " Maryland

12 MAIDEN NAME OF MOTHER Mary K. Gerbig

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) " Md.

14 Informant Mrs. Wm. Severns
(Address) 2510 Frederick ave

15 Filed Jan. 13 1921 Robert P. Harrison, Registrar

JAN 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1921, to Jan. 13, 1921, that I last saw h.. alive on Jan. 13, 1921, and that death occurred, on the date stated above, at 4:05 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia
Acute pyelitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood smear.

(Signed) Winfield M. K. Craig, M. D.

, 19 (Address) St Agnes Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 17 1921
20 UNDERTAKER	ADDRESS
Geo. A. Gerbig	2001 W. Baltimore St

Important. See instructions on back of certificates. Exact Statement of OCCUPA-

D.49873 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49873

CERTIFICATE OF DEATH.

159

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1006 Bennett Place ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Albert Whitney

(Residence in Baltimore: No. 1006 Bennett Place St.; yrs., 47 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 23 (Day), 1873 (Year)

7-AGE, 47 yrs. 6 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)..... 059

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George S. Whitney

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Rosetta Merchant

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Whitney

(Address) 1006 Bennett Place

15- Robert P. Harrison,

Filed....., 191.....

JAN 15 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Suicide by revolver wound of head.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 14, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 1-15, 1921

20-UNDERTAKER H. C. B. Jennings Son

ADDRESS 517 N. Edmondson St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49874 HEALTH DEPARTMENT—CITY OF BALTIMORE D49874

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 13 W Barre ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Griffith

(a) RESIDENCE. NO. 13 W Barre ST., 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ Laura A. Griffith

6 DATE OF BIRTH (month, day, and year) Feb 28 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	10	16	

8 OCCUPATION OF DEACEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Old Bay Line

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John L. Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Liza Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura A Griffith
(Address) 13 W Barre St

15 Jan 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 1 1921, to Jany 13, 1921, that I last saw h. alive on Jany 12, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

a) Cardiac Dilatation 4080

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. D. Smith, M. D.

Jan 16 1921 (Address) 109 N Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship 8 mi Dist. Md.

DATE OF BURIAL: Jan 16 1921

20 UNDERTAKER: F. A. Krause & Son

ADDRESS: 739 Hanover St

How is very important. See instructions on back of certificates. Exact ... ment of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49875 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49875

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Boone

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JAN 15 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1921 to January 12 1921, that I last saw her alive on January 12, 1921, and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(No cerebral hemorrhage)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) J. Sherman, M. D.

1/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health.	ADDRESS

See instructions on back of certificates. Exact date of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sylphax T. Digge

D.49876 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49876

CERTIFICATE OF DEATH. X 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 W Biddle ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylphax T. Diggs

(a) RESIDENCE. No. 217 W Biddle ST., WARD. Petersburg Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jessee Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Humphreys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Monroe.

(Address) 217 W Biddle st

15 Filed 15 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 14, 1921, that I last saw h.. alive on Jan 14, 1921, and that death occurred, on the date stated above, at 10:35 A. m.

The CAUSE OF DEATH* was as follows: over

Parenchymatous Nephritis (duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) None. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. D. Wright M. D.

Jan 14. 1921 (Address) 1709 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Va	Jan 16 1921

20 UNDERTAKER Geo W Holland

ADDRESS 1601 Penna Ave and

Sec. 3. Important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably chronic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49877 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49877

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 E. Madison St ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Patterson

(a) RESIDENCE. No. 1408 E. Madison St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER William Glee

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Baltimore

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not Known

14 Informant Peary Butler

(Address) 1408 E. Madison St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JAN 15 '21 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1921

17

I HEREBY CERTIFY, That I attended deceased from December 19, 1920, to January 12, 1921, that I last saw h[illegible] alive on January 12, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy & Bright Disease

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Bright Disease & Complications

Disease (duration) ... yrs. 5 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. A. W. Kennard, M. D.

1-13, 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Jan 16 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Av

Important. See instructions on back of certificates. Exact address of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49878 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 6 WARD) 110

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Wheeler

(a) RESIDENCE. No. 2633 N. Spring ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellsworth Wheeler

6 DATE OF BIRTH (month, day, and year) February 8 81

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Washing & Ironing

(b) General nature of industry, business, or establishment in which employed (or employer) OHI

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel (State or country) Co. Md.

12 MAIDEN NAME OF MOTHER Lillian Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel (State or country) Co. Md.

14 Informant (Address) Hospital Records New City Hospital

15 Filed Robert P. Harrison, Registrar

NOV 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Jan. 13, 1921

that I last saw h.e alive on Jan 13, 1921

and that death occurred, on the date stated above, at 12.25 m.

The CAUSE OF DEATH* was as follows:

Multiple Fistula en ano and ulceration Colitis

(duration) yrs. 6 mos. 13 ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden M. D.

1-13 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 17 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

Fill in all items if possible. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

V 10.49879

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.49879

10-119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Jasper St.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry W. Green

(Residence in Baltimore: No. 605 Jasper St.; 42 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Feb. (Month) 14 (Day), 1878 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 11 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Unemployed

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Washington Green

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beulah E. Green (Wife)

(Address) 605 Jasper Street

15- Dec....., 191..... Robert T. Harrison, Registrar.

JAN 15 1921 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921 to Jan 13 1921, that I saw h[illegible] alive on Jan 13 1921, and that death occurred, on the date stated above, at 9.10 a m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) ..... yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) [signature] M. D.

Jan 15..., 1921 (Address) 1413 Dolphin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Jan. 17., 1921
20-UNDERTAKER Jno. M. Johnson	ADDRESS 1334 Eutaw St.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49880 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 McHenry St.; 19 9-09 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaretta M. Sparrow

(Residence in Baltimore: No. 1818 McHenry St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 13 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 8 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter Sparrow

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaretta Kessler

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter L. Sparrow

(Address) 1818 McHenry St.

15-

JAN 15 1921 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to Jan 14 1921, that I saw h[illegible] alive on Jan 14 1921, and that death occurred, on the date stated above, at 7 20 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

Influenza

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Robert C. Kelly M. D.

Jan 15, 1921 (Address) 2151 Gilmore Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Jan 15, 1921
20-UNDERTAKER	ADDRESS
Harry L. Witzke	1531 W. Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

D.49881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49881

CERTIFICATE OF DEATH.

+30-010

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Isabel Forwood Archer

(Residence in Baltimore: No. Woman's Hospital St.; 30 yrs., 3 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	married

6-DATE OF BIRTH, June (Month) 17 (Day), 1891 (Year)

7-AGE, 30 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Lawrence Forwood.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Jennie Forwood

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. Archer

(Address) Bel Air, Md.

15- JAN 15 1921, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 14 1921, to Jan. 15 1921, that I saw h[er] alive on Jan. 15 1921, and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis

NR 1

..... (Duration) ....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

..... (Duration) ....yrs....mos. 21 ds.

(Signed) Francis Wentworth Winterston M. D.

Jan. 15, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 30 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Bel Air, Maryland.

Former or usual residence Bel Air, Maryland.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bel Air - Md	Jan 15, 1921

20-UNDERTAKER Stewart & Monroe Co (W. S. Monroe) (Asst.) ADDRESS [illegible] North

Remarks Autopsy Findings

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49882 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49882

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia E Eggert (Sr Dolorosa)

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X X

6 DATE OF BIRTH (month, day, and year) Jan 29 1842 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious Sis of Charity

(b) General nature of industry, business, or establishment in which employed (or employer) Nursing

(c) Name of employer Mt Hope Retreat

9 BIRTHPLACE (city or town) (State or country) Not Known Maryland

PARENTS

10 NAME OF FATHER John G. Eggert

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary M. Franka

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed JAN 15 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1920, to Jan 15th, 1921, that I last saw h.. alive on Jan 2nd 14, 1921, and that death occurred, on the date stated above, at At 1 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Senile -

Abt (duration) 30 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Senility - Atheromatous Degeneration

Abt (duration) 3 or 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Jan 15th 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	Jan 17 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

See instructions on back of certificates. Exact statement of OCCUPA- should state ...ng or property classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D49883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49883

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1415 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Mueller

(Residence in Baltimore: No. 445 Hanover St.; 54 yrs., 2 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct 20th, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Doepfer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Mueller

(Address) 445 Hanover St

15-JAN 16 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 14, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Jan 14 1921, that I saw h[illegible] alive on Jan 14 1921, and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 6 mos. ... ds.

(Signed) [signature] M. D.

1/15, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	Jan 17, 1921.
20-UNDERTAKER F. Schlosser & Son	ADDRESS 839 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Smith

D 49884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825- Penn Ave ST. 14 1/2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Smith

(a) RESIDENCE. NO. 1825- Penn Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Elmira Smith

6 DATE OF BIRTH (month, day, and year): Feb 14 1845

7 AGE: Years 75 Months 11 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gov

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Co Md.

PARENTS

10 NAME OF FATHER: Elin Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Richard Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lewis E Smith
(Address): 825- Penn Ave

15 Filed JAN 16 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to Jany 15, 1921, that I last saw h[im] alive on Jany 15, 1921, and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral insufficiency

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H L Holzath, M. D.

, 19 (Address) 728 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Jan 17 1921

20 UNDERTAKER: Wm Cook

ADDRESS: N & G Ave.

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

11 10556 / 11 49885

HEALTH DEPARTMENT—CITY OF BALTIMORE

9-04 49885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Pleasher

(a) RESIDENCE. NO. 442 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child - pat

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Lawrence Pleasher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Irene Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Hospital records

15 Filed JAN 16 1921 ROBERT E. LEE BOOTH Registrar of Vital Statistics Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1921, to Jan 15, 1921, that I last saw h.. alive on Jan 15, 1921, and that death occurred, on the date stated above, at 12 N. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Laryngeal

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Carlisle S. Lentz, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1/16 1921
20 UNDERTAKER: William Cook	ADDRESS: 507 E Wall Ave

See instructions on back of certificates. Exact statement of OCCUPA- should state ... important. ... be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

049886

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 049886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Pennington Ave; 13 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Kulchinsky

(Residence in Baltimore: No. 729 Pennington Ave St.; ....yrs., ...mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	single

6-DATE OF BIRTH, Dec. (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs. 30 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——000
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), U. S. A. Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Kulchinsky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Burligh

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Rosenthal

(Address) 2323 Eutaw Ave

15- Filed JAN 16 1921, 191.... ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 14th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15th 1920, to Jan 14th 1921, that I saw h[illegible] alive on Jan 14 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: over

Congenital

(Duration) ....yrs. ....mos. 30 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Paul M. Rosenthal M. D.

Jan 15, 1921. (Address) 2323 Eutaw Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rose Hill	Jan 18, 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balt

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L49887 — 24 L49887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry D. Finkler

(a) RESIDENCE. No. 2109 E. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rekka Lesansky

6 DATE OF BIRTH (month, day, and year) Mar 3, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Charles Finkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Harbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs. Harry D. Finkler
(Address) 2109 E. Baltimore St.

15 Filed JAN 16 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1921, to Jan 14, 1921, that I last saw h[illegible] alive on Jan 14, 1921, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney (?)

Symptoms 4 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative shock Half-hour (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore City

Did an operation precede death? Yes Date of Jan 14th 1921

Was there an autopsy? No

What test confirmed diagnosis? Nephrectomy

(Signed) T. H. Turner Baum, M. D.

Jan 14 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Jan 16 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E. Balt

Important. See Instructions on back of certificates. Exact statement of OCCUPA- ... state ... properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

049888

HEALTH DEPARTMENT—CITY OF BALTIMORE

049888

CERTIFICATE OF DEATH.

1, 20

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Goodman

(Residence in Baltimore: No. 1936 E. Fayette St.: 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1895.
(Month) (Day) (Year)

7-AGE, 25 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 031

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Morris Goodman

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Shana Lieberman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Louis

(Address)..... 1411 E Baltimore St

15 JAN 16 1921 ROBERT B KRAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. 15, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15th. 1920, to Jan. 15th. 1921, that I saw h[im] alive on Jan. 15th. 1920, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

..... Nephritis .....

.....

.....

..... (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation.

..... (Duration) yrs. mos. 1 hr.

(Signed) J. J. Birnberg M. D.

1/15, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State 16 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1936 E. Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt. Carmel

DATE OF BURIAL, Jan. 18, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt

Spec.—6-9-19—H. P. Co.—1000 Bks.

649889 HEALTH DEPARTMENT—CITY OF BALTIMORE 649889

CERTIFICATE OF DEATH. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 E. Eager ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fowler

(a) RESIDENCE. No. 1612 E. Eager ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 mln.
	—	—	—	1 hrs. 5 mln.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ernest L. Fowler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Lola Kane

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant R. Riddall
(Address) Johns Hopkins Hospital

15 Filed JAN 16 1921 ROBERT T. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 15, 1921, that I last saw him alive on Jan 15, 1921, and that death occurred, on the date stated above, at 10 50 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. L. Leon, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Jan 17 1921
20 UNDERTAKER	ADDRESS
J. Henry Lutz	1007 N Bond

Burial Permit [illegible]

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

044890 — 20 — 044890

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Jefferson St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Wilhelmine Bansbach

(a) RESIDENCE. No. 2418 Jefferson St., 6 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bansbach

6 DATE OF BIRTH (month, day, and year) Sept 16 1836

7 AGE 84 Years 3 Months 29 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl F Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Veronika Ifeldt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gotfried Engel
(Address) 2418 Jefferson St

15 Filed JAN 16 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jany 15, 1921, that I last saw h[illegible] alive on Jany 14, 1921, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Infirmities of old age

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J S T Collier, M. D.

(Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuels Cemetery	Jan 17 1921
20 UNDERTAKER	ADDRESS
Louis Heemann	32 S Broadway

(Over)

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infection caused by cutting toe nail.

049891 HEALTH DEPARTMENT—CITY OF BALTIMORE 049891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1946 Edmondson Ave ST.: 16 WARD) REGISTERED No. C 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena Greenfield

(Residence in Baltimore: No. 1946 Edmondson Ave. St.; yrs., 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED,~~ WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, September 18, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Hungary

PARENTS.

10-NAME OF FATHER, Joseph Schnuermacher

11-BIRTHPLACE OF FATHER (State or Country), Hungary

12-MAIDEN NAME OF MOTHER Helena Schnuermacher

13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Greenfield

(Address) 1946 Edmondson Ave

15- Filed JAN 16 1921 191. ROBERT J. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by illuminating gas, (accident) (1½ hr.)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. D. Hennessy M. D.
(Coroner.)

Jan. 15, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Jan 16 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mod ave

Instructions on back of certificate. Exact statement of OCCUPATION is very important and should be properly examined.

a part of gas fixtures; [illegible]
free flow of gas into closed bedroom
Dr. D. R.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene.*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049892 HEALTH DEPARTMENT—CITY OF BALTIMORE 049892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 9 WARD) 17

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Cecilia Zyzhoff.

(a) RESIDENCE. No. 518 E. 28th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61 yrs.	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma A Thayer

(Address) 518 E 28th St.

15 JAN 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 21, to Jan 15, 19 21, that I last saw h alive on Jan 15, 19 21, and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Fracture neck of femur. (Over)

(duration) yrs. mos. 1 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	January 18 1921
20 UNDERTAKER	ADDRESS
Gott Funeral Co	1422 Park Ave

Issued Permit Clerk

Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

049893

HEALTH DEPARTMENT—CITY OF BALTIMORE

049893

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Park Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Vannort

(a) RESIDENCE. No. 2016 Park Ave ST., WARD. Chesterton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alletta A. Vannort

6 DATE OF BIRTH (month, day, and year) Aug 14. 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown (State or country) Maryland

PARENTS

10 NAME OF FATHER William Vannort

11 BIRTHPLACE OF FATHER (city or town) Trenton (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Catherine D. Adams

13 BIRTHPLACE OF MOTHER (city or town) Trenton (State or country) New Jersey

14 Informant James H Chapman Jr (Address) 2016 Park Ave

15 Filed JAN 16 1921 19 ROBERT P. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 15, 1921, that I last saw h[illegible] alive on Jan 15, 1921, and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Left side

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Prostatic Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? X

What test confirmed diagnosis? X

(Signed) James C. Clarke, M. D.

1/16, 1921 (Address) 2 Europe apts. Charles & St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	Jan 16 1921

20 UNDERTAKER Jos Block ADDRESS 1083 W Balto St

Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

049894 HEALTH DEPARTMENT—CITY OF BALTIMORE 049894

CERTIFICATE OF DEATH. 45

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Reich

(Residence in Baltimore: No. 11 E Castle St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 15 (Month) (Day), 1860 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Dietrich Reich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dietrich Kaster

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M Reich

(Address) 11 E. Castle St.

15-

Filed JAN 16 1921, 191.. ROBERT A KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 14 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 14 1921, that I saw h[illegible] alive on Jan 14 1921, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Larynx

7

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Kelly M. D.

Jan 15, 1921. (Address) 102 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery Dru

DATE OF BURIAL, Jan 17, 1921

20-UNDERTAKER Robt J Turner

ADDRESS 1442 Pmy

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

145-041 D49895 — D49895

CERTIFICATE OF DEATH.

X 119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Josephine M. Lamp

(a) RESIDENCE. No. Clarksville Tenn ST., WARD. (Clarksville Tenn)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Wm Lamp.

6 DATE OF BIRTH (month, day, and year) July 2nd 2.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	32	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-wife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Edward A Thop.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Petronella V. Galen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant (Address) J. Hopkins Hospital Records

15 Filed JAN 16 1921 ROBERT B. QUARTIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11 - 1920, to Jan 15, 1921, that I last saw h.Er alive on Jan 15, 1921, and that death occurred, on the date stated above, at 12 57 p m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis DOR

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Clarksville, Tenn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) U K Mason, M. D.

15 T. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksville Tenn	Jan 16 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of acute nephritis unknown. No other abnormal condition

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49896 HEALTH DEPARTMENT—CITY OF BALTIMORE D49896

CERTIFICATE OF DEATH.

91-098

1-PLACE OF DEATH Baltimore, Md.,

REGISTERED NO.....

CITY OF BALTIMORE: (No. 319 Roland Ave., ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kleinle

(a) RESIDENCE. No. 319 Roland Ave., ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of Irene J. Kleinle

6 DATE OF BIRTH (month, day, and year) May 31, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Kleinle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Heinmüller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice G. Kleinle (Address) 319 Roland ave

15 Filed ..... 19 ..... Registrar

JAN 16 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 3, 1921, to Jan 14, 1921, that I last saw him alive on Jan 13, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia

2. Lung Abcess

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Lung Abcess

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) Leslie Y. Gay, M. D.

19 (Address) 1107 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jany 17 1921

20 UNDERTAKER ADDRESS John Quatchett 1201 N. Fayette St.

Instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Probably due to attack
of influenza—3 yrs ago.

Spec.—8-24-14—M. & T.—2000 Bks.

Christopher C. Speed

D49897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49897

CERTIFICATE OF DEATH.

REGISTERED No. C 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 W. Lafayette Av St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. C. Speed

(Residence in Baltimore: No. 1228 W Lafayette Av St.; Ward 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. (Month) 25 (Day), 1840 (Year)

7-AGE, 80 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Speed

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Reeves

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Speed

(Address) Catonsville

15- Filed JAN 16 1921 19.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Jany 14 1921, that I saw him alive on Jany 14 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Uremia Febrosis

(Duration) 3 yrs. mos. ds.

(Signed) Stephen F. Steelman M. D.

Jany 15, 1921. (Address) 1227 Lafayette Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 1/17/21

20-UNDERTAKER W. J. Tichnor & Sons — ADDRESS Hanover Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

Baby Cohen

049898 HEALTH DEPARTMENT—CITY OF BALTIMORE 049898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 10 WARD)

REGISTERED NO. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Cohen

(a) RESIDENCE. No. 830 Aquitaine St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13-1921

7 AGE — Years | Months | Days: 36 hrs | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER Edward Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Mary Roeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Virginia

14 Informant: Hospital Record
(Address) J. H. H.

15 Filed JAN 16 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14- 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 14 —, 1921, to Jan 14 —, 1921, that I last saw h.r alive on Jan 14 —, 1921, and that death occurred, on the date stated above, at 5-0 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatitis

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Emerson, M. D.

1/16 1921 (Address) 1 W Balto md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Helping Rest — DATE OF BURIAL: Jan 16. 21

20 UNDERTAKER: May Levinson — ADDRESS 1127 E Balto St

See instructions on back of certificates. Exact statement of OCCUPATION should be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49899

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Mt. Royal Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. H. Pentland.

(a) RESIDENCE. NO. 1212 Mt. Royal Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude J Pentland

6 DATE OF BIRTH (month, day, and year): abt March 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Registrar 026

(b) General nature of industry, business, or establishment in which employed (or employer): Md. Institute

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore - Md.

PARENTS

10 NAME OF FATHER: James Pentland.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland.

12 MAIDEN NAME OF MOTHER: Hettie Jennings.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S. A.

14 Informant: Gertrude J. Pentland. (Address) 1212 Mt Royal Ave

15 Filed JAN 16 1921 ROBERT I. KRAUTER Registrar Burial Permit Olerk

Pellman - 1221 W Lafayette Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 - 1921.

17

I HEREBY CERTIFY, That I attended deceased from January 11, 1921, to January 14, 1921, that I last saw him alive on January 14, 1921, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Steuben F. Pellman, M. D.

(Address) 1227 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery.	Jan 17 1921.
20 UNDERTAKER: William Cook	ADDRESS: 502 E North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

049900 HEALTH DEPARTMENT—CITY OF BALTIMORE 049900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9th St. Nr 4th Ave. Fairfield ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Meredith

(a) RESIDENCE. No. 9th St. Nr 4th Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Meredith

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	?	?	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ship yard

(c) Name of employer Union Ship Bldg. Co.

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unk known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unk known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Laura Meredith

(Address) 9th St Nr 4th Ave Fairfield

15 Filed JAN 16 1921 BURIAL PERMIT CLERK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1921, to Jan 12, 1921, that I last saw h[illegible] alive on Jan 12, 1921, and that death occurred, on the date stated above, at 1:40 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of employment

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus Type IV

(Signed) Geo. E. Davis, M. D.

1/14, 1921 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 16 1921
20 UNDERTAKER	ADDRESS
R. B. Gross	1405 McElderry

See instructions on back of certificates. Exact statement of OCCUPA-

D49901 HEALTH DEPARTMENT—CITY OF BALTIMORE D49901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 934 Franklin Rd. ST.: 16 WARD) REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Goodwin

(Residence in Baltimore: No. 934 Franklin Rd. St.; yrs., 44 mos. 11 ds. 8)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, February 5, 1876
(Month) (Day) (Year)

7-AGE, 44 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Cornelius Goodwin

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary M. Johnson

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard J. Goodwin

(Address) 1029 N. Broadway.

15- JAN 16 1921 ROBERT J KRAUTER
Filed....., 191.... Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
3 months
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) ...yrs. ...mos. ...ds.

(Signed) J. A. T. Hennessy M. D.
(Coroner.)

Jan. 14, 1921 (Address) 2402 Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, 1/17, 1921

20-UNDERTAKER Henry W. Maus & Son — ADDRESS 805 W. Gaborel St.

INSTRUCTIONS on back of certificate. Exact statement of OCCUPATION is very important. Omissions or errors in any particular, including should state whether

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Public Health Servic Hsopital #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort Mc Henry Baltimore St. Md. 24 WARD 34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholmew J. Regler.

(a) RESIDENCE. NO. U.S. Public Health Service St. Hospital #56 ward 34 WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknwon

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	59 yrs.	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer): -------

(c) Name of employer: -----

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Edgar Rosenbush Registrar Fort McHenry Baltimore Md.

15 Filed JAN 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1920, to Jan. 15, 1921, that I last saw him alive on Jan. 15, 1921, and that death occurred, on the date stated above, at 10'45 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis chronic

unknwon (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No. Date of -----

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J D Reichard, M. D.

, 19 (Address) US. PHS Hosp #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — DATE OF BURIAL: Jan 17 1921

20 UNDERTAKER: Peter Nicolaus — ADDRESS: 2046 Easter

(Instructions on back of certificates. Exact statement of OCCUPATION is required.)

Spec.—8-24-14—M. & T.—2000 Bks.

049903 HEALTH DEPARTMENT—CITY OF BALTIMORE 049903

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3421 Chestnut ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Bailey

(Residence in Baltimore: No. 3421 Chestnut Ave St.; 20 yrs., 2 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, August 20, 1838 (Month) (Day) (Year)

7-AGE, 82 yrs. 4 mos. 24 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Union Balt. Co. Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known.

12-MAIDEN NAME OF MOTHER Sarah Hundesty

13-BIRTHPLACE OF MOTHER (State or Country), Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. E. Bailey

(Address) 3421 Chestnut Ave City

15- Filed JAN 16 1921, 191.. ROBERT P. KRAUTER REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 15, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1920, to Jan 14 1921, that I saw h.er alive on Jan 14 1921, and that death occurred, on the date stated above, at ....m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 yr. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. J. Davies M. D.

1-15, 1921 (Address) 2001 W. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Johns cem | DATE OF BURIAL, Jan 18, 1921

20-UNDERTAKER Easton Sons | ADDRESS Ellicott City

D 49904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D49904

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1631 Clarkson ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Walter

(Residence in Baltimore: No. 1631 Clarkson St. 37 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Jan. 14, 1864 (Month) (Day) (Year)

7 AGE: 56 yrs. 11 mos. 0 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nicholas George

(Address) 1631 Clarkson St

15 JAN 17 1921

Filed ..... 191 ..... ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 14 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1921, to Jan. 14 1921, that I saw h[er] alive on Jan. 13, 1921, and that death occurred, on the date stated above, at 7.30 A.M.
The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Pain Asthma.

(Duration) 1 yrs. 6 mos. - ds.

(Signed) H. Howard Keech M. D.

Jan. 14, 1921. (Address) 219 N. Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross 446 — DATE OF BURIAL: 1-17, 1921

20 UNDERTAKER: E & B Hahn — ADDRESS: 115 E West St

IS VERY IMPORTANT. See instructions on back of certificate. ... that it may be properly classified. Exact statement of OCCUPATION ... should be stated EXACTLY. PHYSICIANS should ... plain terms, so

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49905 HEALTH DEPARTMENT—CITY OF BALTIMORE D49905

CERTIFICATE OF DEATH. 10-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6004 Foster Ave. Govans WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Weigel

(a) RESIDENCE. No. 6004 Foster Ave Govans WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Weigel

6 DATE OF BIRTH (month, day, and year) Oct 3, - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethelem Steel Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Weigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Margaretha Dunkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Rosa Weigel
(Address) 6004 Foster Ave

15 FILED JAN 17 1921 ROBERT A. CRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Jan 14, 1921, that I last saw him alive on Jan 14, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

superinduced by La Grippe

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery	January 17 1921
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St

Ck of certificates. Exact statement of OCCUPA... See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49906

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049906

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH U.S. Public Health Service Hospital #56

REGISTERED NO.....

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. St. 24 WARD) 34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Fritas.

(a) RESIDENCE. No. US. Public Health Service Hsopital #56 ST. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
19.yrs.	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Hawaii.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Krenbuck Registrar

(Address) Fort McHenry Baltimore Md.

15 DATE RECEIVED JAN 17 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14 1921, to Jan. 15, 1921, that I last saw him alive on Jan. 15, 1921, and that death occurred, on the date stated above, at 3:15 am. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Curtis Bay Ordnance Dep U.S.A

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) J. B. Richard, M. D.

, 19 (Address) US. PHS. Hosp. #56 Ft. McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Jan 17 1921
20 UNDERTAKER J. Linwood Bro	ADDRESS 1127 E Balto St

Directions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

044907

HEALTH DEPARTMENT—CITY OF BALTIMORE

044907

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2652 Boone St.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Griffin

(a) RESIDENCE. No. 2652 Boone St., WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Virginia

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 8 55

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margret Womley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Griffin

(Address) 2652 Boone St

15 Filed JAN 17 1921 19.... ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Jan 14, 1921, that I last saw h[illegible]ive on Jan 14, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza and acute Dilatation of heart —

(duration) 1 yrs. 7 mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinary + physical

(Signed) Ed L Hall, M. D.

19 (Address) 1926 23 St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood Park Va	Jan 17 1921
20 UNDERTAKER Mrs Robt Elliott	ADDRESS 725 Ashland Ave

Instructions on back of certificates. Read statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49908

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 W. Henrietta ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Costin

(a) RESIDENCE. No. 233 W. Henrietta ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred hr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unoccupied

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo Costin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Blanche Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Geo Costin

(Address) 233 W. Henrietta

15 Filed JAN 17 1921 19 ROBERT J. BRUTER Registrar

Social Service Director

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/1921

17

I HEREBY CERTIFY, That I attended deceased from 12/28/20, to 1/15/21, that I last saw h... alive on 1/15/21, and that death occurred, on the date stated above, at 10.25 P m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Catarrh

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Deficient milk Supply

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. Bowley, M. D.

1/16, 1921 (Address) 905 S. Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1/17/1921
20 UNDERTAKER	ADDRESS
J. E. Brown & Son	108 N. Montgay

Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49909 HEALTH DEPARTMENT—CITY OF BALTIMORE D49909

CERTIFICATE OF DEATH.

39v

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~John A. Deering~~ J. Marcus Brenning

(a) RESIDENCE. No. 1055 Harford Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 3rd 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Marcus Brenning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Rosener

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Catherine Brenning
(Address) 1055 Harford Ave

15 Filed JAN 17 1921 ROBERT F. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Jan. 15, 1921, that I last saw him alive on Jan. 15, 1921, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of superior maxilla

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H B Mackenzie, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 18 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	130 E Fayette

Back of certificates. See instructions on back. Very important. Exact statement of occupation.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 49910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49910

CERTIFICATE OF DEATH

43

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Mrs. Julia Delaney ST.: 10 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME .....

(a) RESIDENCE. No. 726 Hanford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late John Delaney

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md. USA.

PARENTS

10 NAME OF FATHER James Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr John Delaney (Address) 726 Hanford Ave

15 Filed JAN 17 1921, 19... ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

I HEREBY CERTIFY, that I attended deceased from Jan 9th, 1921, to Jan 16, 1921, that I last saw h[illegible] alive on Jan 16, 1921, and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Rectum Liver (duration) about 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Schmunk M. D.

, 19 (Address) St Josephs Hosp Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 19 1921

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

IMPORTANT. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49911

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 W. Ostend St.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Davis

(a) RESIDENCE. No. 1409 W Ostend ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ODD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Davis

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith D. Simons

13 BIRTHPLACE OF MOTHER (city or town) Hawkins Pt (State or country) Anne Arundel Co Md

14 Informant Mrs Harry Johnson (Address) 1407 W. Ostend St

15 Filed JAN 17 1921 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to Jan 15, 1921, that I last saw h[illegible] alive on Jan 15, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Clinic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 16 1921 (Address) 1520 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marley Church Cemetery	JAN 17 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

Important. See instructions on back of certificates. Exact statement of OCCUPA-

D 49912 Caution D 49912 1920 14 1906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 170

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josh Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josh Caution.

(Residence in Baltimore, No. (Sparks md) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Mar (Month) 13 (Day), 1906. (Year)

7-AGE, 14 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 000
(b) General nature of industry, business, or establishment in which employed (or employer) Schoolboy

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Cox

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sadie Caution

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie Caution

(Address) Sparks Md

15- Filed ... 191... BOTERY & KRAUTER Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound
shot accidentally by brother

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Hall Poteet M. D.
(Coroner)

1-16, 1921 (Address) Sparks Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Sparks Md

19-PLACE OF BURIAL OR REMOVAL, Quaker Bottom Cem Co — DATE OF BURIAL, Jan 18, 1921

20-UNDERTAKER Clarence E Wright — ADDRESS 1564 W Cons'd

Important. See instructions on back of certificate. Exact statement, of OCCUPATION is very ... should state ... property classified.

Spec.—8-24-14—M. & T.—2000 Blks.

D49913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D049913

CERTIFICATE OF DEATH.

36

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Riggs Ave, ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Grayson.

(Residence in Baltimore: No. 1425 Riggs Ave — St.; 1 yrs., 7 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, June 5th, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Md

PARENTS:

10-NAME OF FATHER, Solon Howard

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Grayson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Grayson

(Address) 1425 Riggs Ave

15-Filed JAN 17 1921, 191.. ROBERT B KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 15th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to Jan 15th 1921, that I saw h-- alive on Jan 15th 1921, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows: T.T.W.

Rachitis & Inanition

(Duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis of Heart due to Con-

Tuberculosis (Duration) yrs. mos. 3 ds.

(Signed) Harry F Brown M. D.

Jan 16, 1921. (Address) 1501 Druid wood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W. Auburn

DATE OF BURIAL, Jan 17th, 1921.

20-UNDERTAKER Sam'l W. Grace & Son

ADDRESS 1400 Mosher St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49914 HEALTH DEPARTMENT—CITY OF BALTIMORE D49914

CERTIFICATE OF DEATH.

4 81

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 401 N. Charles ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Hollingsworth Howard.

(a) RESIDENCE. No. 401 N. Charles ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 93 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If married, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of: Frank Hey Howard

6 DATE OF BIRTH (month, day, and year): 1827 11-25

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	93	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Boucher Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Maria Hollingsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Nanny Howard

(Address): 401 N Charles St.

15 Filed JAN 17 1921 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 16 1921

17

I HEREBY CERTIFY, That I attended deceased from November, 1920 to Jany, 1921,

that I last saw her alive on Jany 16, 1921,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) many years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) A Warren Buckler, M. D.

19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old St Pauls Cem

DATE OF BURIAL: 1-18 1921

20 UNDERTAKER: Henry W. Jenkins & Son Co

ADDRESS: W Fulton & Orchard

...ns on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

NOVAK

HEALTH DEPARTMENT—CITY OF BALTIMORE

61 D49915

D49915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Mary Novak

(a) RESIDENCE. NO. 521 N. Patterson Park Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 700

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John J Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna K Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record
(Address) J. H. H.

15 Filed JAN 17 1921, 19 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 16, 1921, that I last saw h~~e~~ alive on Jan 16, 1921, and that death occurred, on the date stated above, at 2.05 a.m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination Puncture

(Signed) W. D. Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Jan 18 1921
20 UNDERTAKER Geo. M. Fink & Son	ADDRESS 811 N Broadway

Funeral Directors & Embalmers

Exact statement of OCCUPA-

See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

L049916

HEALTH DEPARTMENT—CITY OF BALTIMORE

L049916

CERTIFICATE OF DEATH.

39

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2103 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David J. Mc Govern

(Residence in Baltimore: No. 2103 Walbrook Ave St.; 66 yrs., 3 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~Married~~ WIDOWED, OR DIVORCED, (*Write* the word.) Mr

6-DATE OF BIRTH, Oct 13, 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Locksmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James McGovern

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Dyson

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth McGovern

(Address) 2103 Walbrook ave

15-Filed JAN 17 1921, 191.... ROBERT P. LAZENBY Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1 1920, to Jan 14 1921, that I saw him alive on Jan. 14 1921, and that death occurred, on the date stated above, at 6-30 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Mouth
Hard Palate

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Gill Hall M. D.

Jan 15, 1921 (Address) 1617 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Jan 18, 1921

20-UNDERTAKER, W. M. Gaither — ADDRESS 1624 Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D49917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 14 WARD) 20

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Rosenberg,

(Residence in Baltimore: No. 2202 McCulloh St, St.) life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April 9, 1896
(Month) (Day) (Year)

7-AGE, 24 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 045
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jacob Rosenberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca Hamkins

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto St

15- Filed JAN 17 1921, 191.... ROBERT B KRAUSS Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1921, to Jan. 16 1921, that I saw h[im] alive on Jan. 16 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Possible Sepsis
(See Remarks)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) Bro's Isaacs M. D.

Jan 17, 1921. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1

Former or usual residence 2202 McCulloh St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern Ad DATE OF BURIAL, 1/17, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 49918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49918

CERTIFICATE OF DEATH.

55-10

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zelik Rhody

(Residence in Baltimore: No. 34 S. High St. St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month) — (Day) 1871 (Year)

7-AGE, 50 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sexton 086
(b) General nature of industry, business, or establishment in which employed (or employer): Congregation

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15-

Filed JAN 17 1921 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 17 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 14 1921, to Jan. 17 1921, that I saw him alive on Jan. 17 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Benj. Sacks M. D.

(Jan. 17, 1921 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State 1 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 34 S. High St

Former or usual residence "

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Mt Carmel — DATE OF BURIAL, 1-18, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49919

CERTIFICATE OF DEATH.

120 D49919

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Frederick ave ST.; 70 WARD)

2-FULL NAME Catherine C. Duckett

(a) RESIDENCE. NO. 2110 Frederick ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Robert P Duckett

6 DATE OF BIRTH (month, day, and year) Jan 15 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael J Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Cotay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Robert P Duckett
(Address) 2110 Frederick Ave

15 Filed JAN 17 1921 ROBERT F KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1920 to Jan 15 1921, that I last saw h[illegible] alive on Jan 15 1921, and that death occurred, on the date stated above, at 1 40 P m.

The CAUSE OF DEATH* was as follows:

Chr Parenchymatous Nephritis
Endocarditis

(duration) Months

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis

(Signed) Robert C Hubert M. D.

Jan 16 1921 (Address) 715 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 18 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Baltimore St

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049920 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049920

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 Burgundy ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Elsroad

(a) RESIDENCE. No. 940 Burgundy ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Elsroad

6 DATE OF BIRTH (month, day, and year) March 4 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Duke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Cadwa—

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cadwa—

14 Informant Mrs. Rose M. Benner

(Address) 940 Burgundy St.

15 Filed JAN 17 1921 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Jany 15, 1921, that I last saw h.. alive on Jany 15, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Interfered function of bile duct

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Richard Klein, M. D.

, 19 (Address) 1727 Columbus Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan. 18 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49921

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 DeCatur ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel C. Hudson

(a) RESIDENCE. No. 1430 DeCatur ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware.

14 Informant John Lewis (Address) 1400 DeCatur St

15 Filed JAN 17 1921 ROBERT J. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1920, to Jan 15, 1921, that I last saw h[illegible] alive on Jan. 14, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. H. Seabury, M. D.

1/16, 1921 (Address) 638 Fork.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakleum Century.	1/17 1921
20 UNDERTAKER	ADDRESS
Wm. J. Gorsuch Son	1428 S.

Chas. H.

Instructions on back of certificates. Exact statement of OCCUPATION property classified. State state

D49922

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

50 D49922

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 732 Mura ST. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Dinan

(Residence in Baltimore: No. 732 Mura ST. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Single

6-DATE OF BIRTH March 2, 1877 (Month) (Day) (Year)

7-AGE 43 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md

PARENTS

10-NAME OF FATHER Maurice Dinan

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Nora Reardon

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Dinan

(Address) 732 Mura St

15- Filed JAN 17 1921 19.. ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12, 1921, to Jan 15 1921, that I saw her alive on Jan 14, 1921, and that death occurred, on the date stated above, at 3 50 m.

The CAUSE OF DEATH* was as follows:

Diabetis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Diabetis Coma

(Duration) 1 yrs. mos. 2 ds.

(Signed) Jas. M Reardon M. D.

Jan 16, 1921 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Libertytown Md

DATE OF BURIAL Jan 18, 1921

20-UNDERTAKER H. C. Widefeld

ADDRESS 914 Greenmt Ave

IMPORTANT. PHYSICIANS should be very careful that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Robert B. Williamson

D49923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., W Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R. B. Williamson

(a) RESIDENCE. No. Graham Va St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mona Williamson

6 DATE OF BIRTH (month, day, and year) June 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Thos Williamson

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Sallie Nelson

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hosp Record (Address) Mercy Hospital

15 Filed JAN 17 1921 ROBERT I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 16, 1921, that I last saw h alive on Jan 16, 1921, and that death occurred, on the date stated above, at 7 00 P m

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 10

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J W Postlethwaite, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Graham Va	1/17/21
20 UNDERTAKER Geo A Farley Fulton & Fayette	ADDRESS

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49924 HEALTH DEPARTMENT—CITY OF BALTIMORE D49924

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Henson

(a) RESIDENCE. No. 316 E. 22½ St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Henson

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Francis Smallwood

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 17 1921 ROBERT J. KRAUTER Registrar

Medical Examiner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 5, 1920 to January 13, 1921 that I last saw h. in alive on January 13, 1921 and that death occurred, on the date stated above, at 10:00 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. H. Herman M. D.

1/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Mfg. & Supply Co.	Jan 17 1921
20 UNDERTAKER	ADDRESS
George T. A. Gibson	513 Fairmount

See instructions on back of certificates. Exact statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49925

CERTIFICATE OF DEATH.

D 49925

30

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 21 WARD)

2-FULL NAME William Smith

(a) RESIDENCE. NO. 1313 Ward St. Baltimore Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 28. 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Victoria Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): J. Hopkins Hospital Records

15 Filed 1-7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to Jan 15, 1921, that I last saw h[illegible] alive on Jan 15, 1921, and that death occurred, on the date stated above, at 7[illegible] p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) W R Davison, M. D.

Jan 15 1921 (Address) J H H. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 18 1921

20 UNDERTAKER: David Turbert

ADDRESS 916 Eutaw

Sec. 1. Fill out all items. Use ink. Print plainly. Exact statement of OCCUPATION on back of certificates. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 49926 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49926

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 627 W Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther Smith

(a) RESIDENCE. No. 627 W Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Servant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant — Col

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) 627 W. Mulberry st Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) Lumpkinsville (State or country) South Car.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Conway (State or country) South Car.

14 Informant William Smith (Address) 627 W Mulberry st

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

1 7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th 1921, to Jan 15th 1921, that I last saw him alive on Jan 14th 1921, and that death occurred, on the date stated above, at 4 1 A m.

The CAUSE OF DEATH* was as follows:

(a) Due to a slow delivery in a breech presentation with asphyxia requiring 30 Minutes artificial respiration, Debility due to 4 mo. Fits (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D. B. Evans, M. D.

, 19 (Address) Greene & Franklin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn Cem	Jan 16 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	Pc an

Back of certificates. Exact statement of OCCUPA- ... instructions on back ...

Spec.—8-24-14—M. & T.—2000 Bks.

D.49927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Leptonsville Morrell ST.) 25 (WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Mary Kind

(Residence in Baltimore: No. Leptonsville Morrell Park St. Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	Widow

6-DATE OF BIRTH, 2 (Month) 6 (Day), 1865 (Year)

7-AGE, 64 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John J. Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Klipper

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Duvall

(Address) Luton St morrell Park

15-

Filed ....., 191.... Robert T. Harrison Registrar.

17921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1919, to July 14 1921, that I saw her alive on July 14 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart disease

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Contributory Consumption

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Hall M. D.

July 16, 1921 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	July 18, 1921.
20-UNDERTAKER	ADDRESS
Geo Lingenfelter Son	6711 Park St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49928 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49928

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1218 N. Lombard St. ST.: 18 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Galvin.

(a) RESIDENCE. No. 1218 N. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1/19/1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
49	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew Galvin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sarah Abraham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Allard. (Address) 1218 N Lombard St

15 Filed 1/7 1921 Robert P. Harrison Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1920 to Jan. 16, 1921, that I last saw h... alive on Jan. 16. 1921, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Microscopic

(Signed) J. Thaston Hamilton M. D.

1/17. 1921 (Address) 8888 Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Jan 18 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1700 W. Lombard st

...s on back of certificates. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49929 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49929

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S. Washington ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. Eollin

(a) RESIDENCE. No. 209 S. Washington ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Eollin.

6 DATE OF BIRTH (month, day, and year) Feb. 1st 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	11	23	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Retired Steward

(b) General nature of industry, business, or establishment in which employed (or employer) of Tow Boat.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Alfred E. Eollin.

11 BIRTHPLACE OF FATHER (city or town) Norway.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Boyce

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Mary Eollin (Wife)
(Address)

15 Filed 1 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1920 to Jan 15, 1921, that I last saw h[illegible] alive on Jan 14, 1921, and that death occurred, on the date stated above, at 7½ a m.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pulmonary Tuberculosis

Abt (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Geo Heller M. D.

1-16 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan 18th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe St

Instructions on back of certificates. Exact statement of OCCUPATIONS should be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

D.49930 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 W. North Ave. St.; 15 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Teschner

(Residence in Baltimore: No. 3107 W North Avenue St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SEX~~, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, December (Month) 25th (Day), 1844 (Year)

7-AGE, 74 yrs. mos. 21 ds. If LESS than 1 day, hrs. of min.

8-OCCUPATION: 045
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Wait Bros & Rice Broker

9-BIRTHPLACE, (State or Country) Stettin, Germany

PARENTS.

10-NAME OF FATHER, Paul Teschner

11-BIRTHPLACE OF FATHER (State or Country), Stettin Germany

12-MAIDEN NAME OF MOTHER Laura Stroth

13-BIRTHPLACE OF MOTHER (State or Country), Stettin Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta Teschner

(Address) 3107 N. North Ave

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

JAN 17 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January fifteenth (Month) Jany (Day) 15 (Year) 1921

17- I HEREBY CERTIFY, That I attended deceased from October 1919, to Jany 15 1921, that I saw h im alive on Jany 15 1921, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Heart Block

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease (Duration) 15 yrs. mos. ds.

(Signed) Laurence Stroetmann M. D.

1-15-21, 191.. (Address) 3303 Towanda Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, Jany 19, 1921

20-UNDERTAKER A. Sakowitz | ADDRESS North Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49931

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 W North Ave ST.; 15 WARD) 1/20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Wilmot

(Residence in Baltimore: No. 2731 W North Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, June (Month) 4 (Day), 1850 (Year)

7-AGE, 70 yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Geo Boulden

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Rebecca Hall

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Agnes Wilmot

(Address) 2731 W North Ave

15- Registered JAN 17 1921 Robert P. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1920, to Jany 15 1921, that I saw h[er] alive on Jany 14 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Edema

(Duration) yrs. mos. 4 ds.

(Signed) Thomas L Talbott M. D.

1/17, 1921 (Address) Marlboro Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Jan 18, 1921

20-UNDERTAKER W J Tschudy & Sons — ADDRESS North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49932 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49932

CERTIFICATE OF DEATH. 24

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gnseral Hosp ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Revell Steele

(a) RESIDENCE. No. 1106 Madison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	9	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none pp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Geo A. Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Dr Geo A Steele
(Address)

15 Filed JAN 17 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1921, to Jan 16, 1921, that I last saw him alive on Jan 16, 1921, and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis with adhesions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? Yes Date of Jan 8

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) C.O. Dewart, M. D.

1/16, 1921 (Address) Maryland Gnseral Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Ger. Cemetery	Jan 18 1921
20 UNDERTAKER Wm J. Tickner & Sons	ADDRESS N. Pa

Directions on back of certificates. Exact address should be given. Exact address should state number of OCCUPA-

Spec —8-24-14—M. & T.—2000 Bks.

D.49933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49933

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. University Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Adaline DeHaven

(Residence in Baltimore: No. 2912 Bernard St. St.; 7 yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 30, 1901. (Month) (Day) (Year)

7-AGE, 19 yrs. 5 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 137

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Robert McLeod

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Hatton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. L. McHaven

(Address) 2912 Bernard St

15-

Filed ..... 1921 ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 16, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 19 1920, to Jan. 16 1921, that I saw h[illegible] alive on Jan. 16 1921, and that death occurred on the date stated above, at 5:55 A. m.

The CAUSE OF DEATH* was as follows:

Cyclonic Stenosis of Aortic Valves

(Duration) .... yrs. 3 mos. .... ds.

CONTRIBUTORY (Secondary) Partial Subtotal Obstruction Operation - Recovery

(Duration) .... yrs. .... mos. 12 ds.

(Signed) [illegible] M. D.

Jan. 16, 1921 (Address) Univ. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ft. Carmel Cem. DATE OF BURIAL, Jan. 18, 1921

20-UNDERTAKER Chenoweth & Chestnutt ADDRESS

D.49934

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.49934

CERTIFICATE OF DEATH

91

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Harrington Road St.: Morrell Park (WARD) 25)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Helen Margaret Johns

(Residence in Baltimore: No. Harrington Road St.: Morrell Park yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: January (Month) 27, 1920 (Day) (Year)

7 AGE: yrs. 11 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Raymond Johns

11 BIRTHPLACE OF FATHER (State or country): Penna

12 MAIDEN NAME OF MOTHER: Katherine Godfrey

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lena Godfrey
(Address) Morrell Park

15 Robert P. Harrison,
Filed JAN 7 1921, 191
Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 16 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1921 to January 16 1921
that I saw her alive on January 10, 1921,
and that death occurred, on the date stated above, at 7.30 p.m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ... yrs. ... mos. 10 ds

Contributory (SECONDARY) same

(Duration) ... yrs. ... mos. 10 ds.

(Signed) Geo. Sim Liebau M. D.
January 17, 1921 (Address) Morrell Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Mary's (Pimlico) DATE OF BURIAL: Jan 18, 1921

20 UNDERTAKER: C Kenworthy ADDRESS: Belt near Cu

1. AGE should be stated EXACTLY. PHYSICIANS should be very important. See instructions on back of certificate. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49935 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.49935

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E. Cross ST.; 24 WARD)

2-FULL NAME John W. Hirsch

(a) RESIDENCE. NO. 117 E. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie Hirsch

6 DATE OF BIRTH (month, day, and year) Dec 11 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank. Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Rudnitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Georgie Hirsch

(Address) 117 E. Cross st

15 Filed JAN 17 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 5, 1921, to Jany 15, 1921, that I last saw him alive on Jany 15, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious

Pernicious Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examine

(Signed) H. A. Smith, M. D.

, 19 (Address) 109 N. Eu St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Jan 18 1921
20 UNDERTAKER	ADDRESS
F. A. Kranse & Son	703 Hanover

See instructions on back of certificates. Physicians are requested to fill out these certificates carefully, as they are to be properly classified. Exact statement of OCCUPATIONS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49936 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49936

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harford B. Justh

(a) RESIDENCE. NO. 3037 Arunah Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Justh

6 DATE OF BIRTH (month, day, and year) Sept. 6. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothier 045

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm S. Justh

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York N.Y.

12 MAIDEN NAME OF MOTHER Rosa Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Virginia

14 Informant Mrs S Justh
(Address) Washington D C

15 Filed 1 7 1921, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-13, 1921, to 1-16, 1921, that I last saw him alive on 1-16, 1921, and that death occurred, on the date stated above, at 11.53 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L Folsom, M. D.

1/17. 1921 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Jan 19 1921
20 UNDERTAKER Geo W Little	ADDRESS 831 N. Fremont Ave

Instructions on back of certificates. Exact statement of OCCUPATIONS should state properly classified.

Spec.--6-9-19—H. P. Co.—1000 Bks.

D.49937 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49937

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 N. Fulton ST.: 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Robinsow

(a) RESIDENCE. No. 1129 N. Fulton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed or Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not known 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (W)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Guinney

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Gertrude Buck
(Address) 1129 N. Fulton Ave

15 Filed Jan 17 1921 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1920, to Jan 16th, 1921, that I last saw her alive on Jan 16th, 1921, and that death occurred, on the date stated above, at 2:00 P m.

The CAUSE OF DEATH* was as follows:

Burden from ununited Fracture of Neck of Femur. 3 yrs duration Infected from B.C. Sores

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) age (W)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W F Hill, M. D.

1/17. 1921 (Address) 1208 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore Cem

DATE OF BURIAL Jan 18 1921

20 UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Ave

See instructions on back of certificates. Exact statement of OCCUPATION should state particularly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Septicaemia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49938 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49938

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 N. Caroline ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret S. Piersol

(a) RESIDENCE. NO. 1700 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? Lives Butt yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Isaac D. Piersol

6 DATE OF BIRTH (month, day, and year) March 11th 1835

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	85	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Middlesex Co Va (State or country)

PARENTS

10 NAME OF FATHER Wm Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co Va

12 MAIDEN NAME OF MOTHER Unknown Mercer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middlesex Co Va

14 Informant Frank R Piersol (Address) 2214 E Pratt st

15 Filed ....., 19..... Robert P. Harrison, Registrar

171921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1920, to Jan 16, 1921, that I last saw her alive on Jan 16, 1921, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Grippe Pneumonia

Diabetis Mel. (Object duration)

(duration) — yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E H Lamy, M. D.

, 19 (Address) 1501 N. Bond st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 18th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

See instructions on back of certificates. Exact statement of OCCUPATIONS should state properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49939 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49939

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Davicini

(a) RESIDENCE. NO. 318 President St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) [illegible] 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records.
(Address)

15 Filed 1921 . 19 Robert P. Harrison, Registrar

N171921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to Jan 16, 1921, that I last saw h.. alive on Jan 16, 1921, and that death occurred, on the date stated above, at 6:00A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological test

(Signed) C. C. Medairy, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Vincent	January 18 1921
20 UNDERTAKER	ADDRESS
Wendell Roffel & Son	378 Penn

(See instructions on back of certificates. Exact statement of OCCUPATION should state properly classified.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49940 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49940

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Ramsey St ST.: 21 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Timothy

(a) RESIDENCE. No. 919 Ramsey St ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Febry 25—1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick Timothy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Croghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. J. Timothy
(Address) 919 Ramsey St.

15 Filed ....., 19.... Robert P. Harrison, Registrar

71921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15 1921

17 I HEREBY CERTIFY, that I attended deceased from Dec, 1920, to Jany 15, 1921, that I last saw h alive on Jany 15, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interst. Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen E. Ward, M. D.

19, (Address) 1227 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem.	Jan 18 1921
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	701 Hollins St

...ATE ... should state ... properly classified. Exact statement of OCCUPA-... on back of certificates.

D.49941 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49941

X 169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. REGISTERED No. C.....

CITY OF BALTIMORE (No. Fort Avenue & Pier St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Demopes.

(Residence in Baltimore: No. N. 5. Bond St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Playtesty.

(Address).....

15- Robert P. Harrison,

Filed ....., 191.....

1-7-1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Jan 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning (accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Black M. D.
(Coroner.)

1-7-1921 (Address) 943 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL, Baltimore n-J- DATE OF BURIAL, Jan. 17 1921

20-UNDERTAKER George L. Ruth ADDRESS 1735 Hayford Ave.

20.49942 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49942

CERTIFICATE OF DEATH.

4 175-003

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Leon Plaat

(Residence in Baltimore: No. York. Pa. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Sept 23 1884 1 (Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer): Pa. R.R. Co.

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hosp

(Address)

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

171921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture - liver, spleen and int. abr. Caused by being crushed between car & platform at Highland yard Penna R.R.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) W. Finley M. D. (Coroner.)

Jan 17, 1921. (Address) 163 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, York Pa

DATE OF BURIAL, Jan 21, 1921

20-UNDERTAKER A S Marshall

ADDRESS 359 W North Ave

(1) Name should be stated EXACTLY. PHYSICIANS should state whether single, married, widowed or divorced. Exact statement of OCCUPATION is very important. Other items may be properly classified. Exact statement of CAUSE OF DEATH is necessary. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49943 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49943

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2617 N. Charles Street ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oliver Horsey

(a) RESIDENCE. No. 2617 N. Charles St. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 62 yrs. 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Divorced.

5a If married, widowed, or divorced HUSBAND of [redacted] Elizabeth Atwell.

6 DATE OF BIRTH (month, day, and year) Jany-9-1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	0	8	

8 OCCUPATION OF DEACEASED 080

(a) Trade, profession or particular kind of work Retired from the

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Tailoring

(c) Name of employer Industry.

9 BIRTHPLACE (city or town) (State or country) Crisfield, SomersetCo Maryland.

PARENTS

10 NAME OF FATHER Oliver S. Horsey

11 BIRTHPLACE OF FATHER (city or town) Somerset Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elvira H. Cox.

13 BIRTHPLACE OF MOTHER (city or town) SomersetCo. (State or country) Maryland.

14 Informant (Address) IsaacP. Horsey, (brother) Crisfield, Maryland.

15 [illegible] Robert F. Harrison, 19.....

71921 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1921, to Jan 17, 1921, that I last saw him alive on Jan 17, 1921, and that death occurred, on the date stated above, at 1040 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) Robert Winchell, M. D.

Jan 19 21 (Address) 1117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield, Somerset CO., Md	Jan-18-1921

20 FUNERAL DIRECTOR AND EMBALMER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

See instructions on back of certificates. Exact statement should state properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49944 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49944

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hosp ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac St. Shirk

(a) RESIDENCE. NO. 2418 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	63	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Isaac Shirk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine S. Cord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Shirk (Address) 2418 St. Paul St.

15 Filed 1/19 21, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 17, 1921, that I last saw h m alive on Jan 17, 1921, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uraemia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo Elsbur Mayer, M. D.

1/17, 1921 (Address) Maryland Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Jan 19 1921.
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

IMPORTANT. PHYSICIANS should state name of informant. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49945 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D.49945

CERTIFICATE OF DEATH.

1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 W Lafayette Ave T.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elyza R Reall

(a) RESIDENCE. No. 1613 W Lafayette Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widow of Edward H Reall

6 DATE OF BIRTH (month, day, and year): April 17 1866

7 AGE: Years 54 Months 8 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John W Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Hollingshead

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): R E Carson 423 Mercy Balto

15 Filed Jan 17 1921 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920, to Jan 16, 1921, that I last saw h[illegible] alive on Jan 16, 1921, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Typhoid fever

(duration) — yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hem - Widal Negative

(Signed) W Bowman Hood, M. D.

Jan 17 1921 (Address) 626 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 19 1921

20 UNDERTAKER: W Black — ADDRESS: 502 E North Ave

INFORMATION is very important. See instructions on back of certificates. Every item of information must be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D.49946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3739 Park Heights Ave 15 WARD)

REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha B Smith

(Residence in Baltimore: No. 3739 Park Heights Ave St.; 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov (Month) 10 (Day), 1866 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 2 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Phillip Stevens

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Susan Grun

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel B Scaggins

(Address) 3739 Park Heights Ave

15- Robert F. Harrison,

Filed....., 191.... Registrar.

1/17/1971 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 17 (Day), 1971 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1971, to Jan 17 1971, that I saw h.er alive on Jan 15 1971, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bright's Disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. Duncan M. D.

Jan 17, 191.. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sandy Park — DATE OF BURIAL, Jan 20, 191..

20-UNDERTAKER — ADDRESS

W. Back 502 E Northern

Spec.—6-9-19—H. P. Co.—1000 Bks.

0049947

HEALTH DEPARTMENT—CITY OF BALTIMORE

0049947

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 North Front St ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta Rachael Hurst

(a) RESIDENCE. No. 224 North Front St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Joseph Hurst

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Custon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Joseph Hurst
(Address) 224 No Front St

15 Filed JAN 18 1921 19 ROBERT B. FRAZIER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-21 19

17 I HEREBY CERTIFY, That I attended deceased from October 1st, 1920, to January 18th, 1921, that I last saw her alive on January 10th, 1921, and that death occurred, on the date stated above, at 12-15 a m.

THE CAUSE OF DEATH* was as follows:

Bronchial Asthma

about 3 years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Complication about (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 146 West High St

Did an operation precede death? Yes Date about 10 years ago

Was there an autopsy? No

What test confirmed diagnosis? Regular form of Diagnosis

(Signed) L. H. Woodward, M. D.

19 (Address) 6 North Front St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodef Sc	1/18 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1911 Eden St

See instructions on back of certificates. PHYSICIANS should be careful to have cause properly classified. Exact statement of OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks.

Baranowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49948 — 40 D49948

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Felix Baranowski

(Residence in Baltimore: No. 619 S. Bond St.; 49 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Nov. 28, 1871 (Month) (Day) (Year)

7-AGE, 49 yrs. 1 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. O. Rail Road

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Jacub Baranowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rozalia Pikora

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Baranowski

(Address) 1614 Aliceanna St

15- Filed JAN 18 1921 191.... ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1921, to Jan. 15 1921, that I saw him alive on ..... 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Stricture of oesophagus due to a Neoplastic growth

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Starvation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Freedom M. D.

1/17....., 1921. (Address) 918 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Jan. 19, 1921.

20-UNDERTAKER John B. Weber — ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049949 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049949

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 Brantly Av ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Ahrendt

(a) RESIDENCE. NO. 1044 Brantly Av ST., 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 30, 1895

7 AGE: 25 Years 7 Months 17 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Henry Ahrendt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Carrie Himler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Henry Ahrendt

(Address) 1044 Brantly Av

15 Filed JAN 18 1921 19.. ROBERT I. CRAIGHILL Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Jan 17, 1921, that I last saw her alive on Jan 17, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

Had been at Sanatorium for 7 months

Came home several mos ago

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none except Symptoms & general condition

(Signed) Chas. H. Bulant, M. D.

, 19 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Lawn Cemetery

DATE OF BURIAL: 1-20-21 19..

20 UNDERTAKER: G. F. Walker

ADDRESS: 723 W. Lafayette Ave

...ate instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L049950 L049950

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. Lombard and Greene Sts WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Gearing (Gearing)

(Residence in Baltimore: No. 918 N. Collington Ave St.; 31 ~~45~~ yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Jan 31, 1875 (Month) (Day) (Year)

7-AGE, 45 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... laborer 173
(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O R.R.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, William Gearing

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER J. T. Heaton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Gearing

(Address) 918 N. Collington

15- Filed JAN 18 1921 ROBERT I. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1920, to Jan 17 1921, that I saw him alive on Jan 17 1921, and that death occurred, on the date stated above, at 3.9 m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Secondary Chronic arterial hypertension and myocarditis

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A. Hurdlett M. D.

Jan. 19, 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. 24 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? N.

Former or usual residence 918 Collington Ave

19-PLACE OF BURIAL OR REMOVAL, Balto Elm. DATE OF BURIAL, Jan. 20 1921

20-UNDERTAKER Phillip Herwig ADDRESS 3016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49951

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Light St. 40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Shainity

(a) RESIDENCE. No. 825 Light ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Kefel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant S Shainity
(Address) 825 Light St

15 Filed JAN 18 1921 ROBT. P. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from December, 1920, to Jan 17, 1921, that I last saw h.. alive on Jan 17, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Symptoms a few weeks

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. { Enlarged nodular liver - other causes not ruled -

What test confirmed diagnosis?

(Signed) Frank R. Smith, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	Jan 18 1921
20 UNDERTAKER	ADDRESS 1127
Max Feuer	E. Balto st

See instructions on back of certificates. Exact statement of OCCUPATION must be properly classified. Should state

Spec.—8-24-14—M. & T.—2000 Bks.

D49952 HEALTH DEPARTMENT—CITY OF BALTIMORE D49952

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Duncan St.; 7 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Bias

(Residence in Baltimore: No. 511 N Duncan St. St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1859 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd Fellows

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Bias

(Address) 723 Walsche

15-

Filed JAN 18 1921 ROBERT B. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 16 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 16 1921, that I saw him alive on Jan 15, 1921, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) Et. Hemorrhage

..... (Duration) .....yrs. .....mos. 3 ds.

(Signed) Adolph E. Elliott M. D.

Jan 17, 1921 (Address) 2201 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Jan 19, 1921
20-UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Blks.

Hammond

D49953 HEALTH DEPARTMENT—CITY OF BALTIMORE D49953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Mosher ST. 14 WARD) 28

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Hammond

(Residence in Baltimore: No. 629 Mosher St.; 23 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 26, 1898 (Month) (Day) (Year)

7-AGE, 23 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Pennington

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER, Hannie Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hammond

(Address) 629 Mosher St

15-

Filed JAN 18 1921 ROBERT J. KRAUTER Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Jan 16 1921, that I saw her alive on Jan 16 1921, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) yrs. 1 mos. ds.

(Signed) C. A. Florence M. D.

Jan 18, 1921 (Address) 715 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Jan 19, 1921

20-UNDERTAKER Sam'l. W. Crawford — ADDRESS 1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Blks.

D49954

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D49954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2927 E Millerimon ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Scheldwachter

(a) RESIDENCE. No. 2927 E Millerimon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Scheldwachter

6 DATE OF BIRTH (month, day, and year) April 12-1848

7 AGE 72 Years	Months 9	Days 29	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gustave Fackel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Angie E Steele

(Address) Westminster

15 Filed ....., 19.... ROBERT B KRAUTER

JAN 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to Jan 17, 1921, that I last saw h.e alive on Jan 18, 1921, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Chron. Dist. Nephritis

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma B Leonard M. D.

1/15/21 (Address) 718 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Jan 18 1921
20 UNDERTAKER	ADDRESS
Jas C Miller	2384 Jefferson St

Should state may be properly classified. Exact statement of OCCUPA- important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 49955 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49955

176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N. Amity ST.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mitchell

(Residence in Baltimore: No. 232 N. Amity St. 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1859 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Cambridge Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Mitchell

(Address) 232 N. Amity St

15- ROBERT J. KRAUTER

Filed JAN 18 1921 191. Burial Permit Clerk

JAN 18 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7th 1921, to Jan 14 1921, that I saw h~~im~~ alive on Jan 14 1921, and that death occurred, on the date stated above, at 2.05 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Larynx

Hypertrophied Prostate

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) D. B. Hughes M. D.

Jan 16 1921 (Address) 1413 E. Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL, Jan 19 1921

20-UNDERTAKER Samuel Feasley | ADDRESS 578 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 49956

D 49956

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 562 Preston St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Murray

(Residence in Baltimore: No. 562 Preston St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown, 1856
(Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook, Rest
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Private

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Lewis Thompson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. Md

12-MAIDEN NAME OF MOTHER Mahala Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Morris

(Address) 1123 N. Mc Culloh St

15- ROBERT J. KRAUTER

Filed ....., 191. Burial Permit Clerk.

JAN 18 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 15th., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10th 1921, to Jan 14th 1921, that I saw ~~her~~ alive on Jan 14th 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fair Diabetes

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. Ellis M. D.

1-17-21, 191.., (Address) 562 Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Jan 18th, 191..

20-UNDERTAKER Samuel Stanley ADDRESS 578 W Baltimore St

Remarks

No further history than senile pneumonia

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Albin Hotel

CITY OF BALTIMORE: (No. Richmond Eastern St. 11 Ward) 79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Grotjan Cook

(a) RESIDENCE. No. Albin Hotel St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm. W. L. Cook

6 DATE OF BIRTH (month, day, and year) Unknown 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisville Ky

PARENTS

10 NAME OF FATHER Thomas J. Grotjan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa

12 MAIDEN NAME OF MOTHER Sarah F. Bigger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville Ky

14 Informant Thomas G Cook
(Address) Tuxedo Park Newyork

15 Filed JAN 18 1921 19 ROBERT E. LYNCH Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29th 1919, to Jan 17th 1921, that I last saw her alive on Jan 12th 1921, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Oedema of Lungs
secondary to Dilatation of Heart.
Oedema lasted 15 minutes,

(duration) 1 yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fluroscopic X Ray

(Signed) Gordon Wilson, M. D.

Jan 17 1921 (Address) 46 E. Preston St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 19th 1921

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS Orchard and Eutaw

Important. See instructions on back of certificates. Names may be properly classified. Exact statement of OCCUPATION should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill:* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc*. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Information as to this death reported to the coroner, Wm. J. Kelly, and permission obtained from him to issue this certificate

Spec.—8-24-14—M. & T.—5000 lbs.

D 49958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 49958

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Robert ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie MacBeth

(Residence in Baltimore: No. 547 Robert St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown (Month) ..... (Day) ....., 1886 (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waitress
(b) General nature of industry, business, or establishment in which employed (or employer): 870

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, James MacBeth

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle Winston (Cousin)

(Address) 547 Robert St.

15- ROBERT E KRAUTER

Filed JAN 18 1921 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Jan 16 1920, that I saw her alive on Jan 16 1920, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. E. Daughtery M. D.

Jan 17, 1921 (Address) 1602 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Jan 17, 1921

20-UNDERTAKER Mrs Robt A Elliott ADDRESS 1725 Madison Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49959 HEALTH DEPARTMENT—CITY OF BALTIMORE D 49959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Johnson.

(a) RESIDENCE. No. 514 Shields Alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Annie Young.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Augustus Johnson
(Address) 514 Shields Alley

15 Filed JAN 18 1921, 19 ROBERT F. CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1920, to January 15, 1921, that I last saw h... alive on Jan 15, 1921, and that death occurred, on the date stated above, at 1.40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic sputum

(Signed) L. J. Rigney, M. D.

, 19 (Address) Bayview hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Jan 18 1921
20 UNDERTAKER	ADDRESS 1140 W
Brown & Freeland.	Edmondson

Sec. 3. Certificates of Deaths from Tuberculosis may be properly classified. Exact statement of OCCUPATIONS should be made on back of certificates.

049960 HEALTH DEPARTMENT—CITY OF BALTIMORE 049960

CERTIFICATE OF DEATH.

K 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 4 Pier 4 St.; 4th & WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Coyle

(Residence in Baltimore: No. New York. 290 10th Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman ooo
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).
New York City

PARENTS.

10-NAME OF FATHER, John Coyle

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Margaret Hanley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Coyle

(Address) 290- 10th Ave. N.Y.C.

15- JAN 18 1921 ROBERT A KRAUTER
Filed....., 191.....
Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 16th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Contributory
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clumsy M. D.
(Coroner.)
Jan 18, 1921. (Address) 63 Penn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Fell from gang way

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New York City N.Y.	Jan 18th, 1921
20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balt St

(1) Exact statement of OCCUPATION is very important. PHYSICIANS should state specially classified. (2) Exact statement of CAUSE OF DEATH is very important. See on back of certificate.

D49961 HEALTH DEPARTMENT—CITY OF BALTIMORE D49961

CERTIFICATE OF DEATH.

167

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2218 W Fayette ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret E. Painter

(Residence in Baltimore: No. 2216 W. Fayette St.; yrs., 1 mos. 3 ds. 10)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 7, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. M. Painter

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Rose E. Clarke

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. M. Painter

(Address) 2218 W. Fayette St

15- FILED JAN 18 1921 ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental run Chest to Head

(Duration) yrs. 1 mos. ½ ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

(Signed) James H. Teale M. D. (Coroner.)

June 17, 1921 (Address) 7 and E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, June 19, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bate St

INSTRUCTIONS. PHYSICIANS should state CAUSE OF DEATH CLEARLY. Exact statement of OCCUPATION is very important. Certificates improperly classified. Exact statement of OCCUPATION is very may be properly filled out. See instructions on back of certificate.

Pulled vessel with hot water off stove + scalded herself

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 49962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49962

93

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 N. Calvert. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. O'Connell.

(a) RESIDENCE. No. 2816 N. Calvert ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower.

5a If married, widowed, ~~or divorced~~
HUSBAND of ~~WIFE of~~ Eugenia O'Connell

6 DATE OF BIRTH (month, day, and year) Mar. 11th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	10		

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Grain Salesman

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Conry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Wm. O'Connell
(Address) 2816 N. Calvert St

15 Filed JAN 18 1921, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1921, to January 16th, 1921, that I last saw him alive on January 16th, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion, and pleurisy, ~~some~~

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis & Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? N.V. Date of .....

Was there an autopsy? N.A.

What test confirmed diagnosis? Symptoms & Examination

(Signed) Wm. H. Smith, M. D.

1/18, 1921 (Address) 1505 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cherbathodal Cem	1-19- 1921
20 UNDERTAKER J. A. Inman	ADDRESS 3000 E Baltimore

Sec. 2. ... may be properly classified. Exact statement of OCCUPA-TIONS should state ... See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history for tuberculosis. No organic heart disease.

Spec.—5-19-13—M. & T.—500 Bks.

049963 HEALTH DEPARTMENT—CITY OF BALTIMORE 049963

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 W. Lanvale st ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joe Frank Griffin

(Residence in Baltimore: No. 1306 W. Lanvale st St.; 50 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-[redacted] WIDOWED [redacted], (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, July (Month) 23 (Day), 1865 (Year)

7-AGE, 56 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Builder.
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, James C. Griffin

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Elizabeth Ann Prather

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas W Griffin

(Address) 1803 N Mulberry St

15- Filed JAN 18 1921, 191 Robert F. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1920, to January 1921, that I saw him alive on January 17th 1921, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Neck

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt. F. Lee Lunsford M. D.

Jan 18th, 1921 (Address) 11 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
LOUDON PARK CEM	JAN 20, 1921
20-UNDERTAKER Robert Brockerson	ADDRESS CALHOUN HOLLINS ST

Spec.—8-24-14—M. & T.—2000 Bks.

D.49964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49964

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Marshall ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Hartman

(Residence in Baltimore: No. 1109 Marshall St. Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1849 (Year)

7-AGE, 71 yrs. ..... mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Miller.

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Hartman

(Address) 22 E. West St.

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

N181991 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 17th 1921, that I saw her alive on Jan 16th 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. (Apoplexy)

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B. Roe M. D.

Jan 17th, 1921. (Address) 1303 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, Jan 19, 1921

20-UNDERTAKER Margaret D. Flynn — ADDRESS 1417 Light St

Remarks .....

Apoplectic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions,
Hæmorrhage, Gastritis, Erysipelas, Meningitis,
Gangrene, Miscarriage, Necrosis, Peritonitis,
Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

D.49965

HEALTH DEPARTMENT---CITY OF BALTIMORE

D.49965

CERTIFICATE OF DEATH

42

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1232 Hull ST.: 24 WARD)

2-FULL NAME Ella Willis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1232 Hull St. Lpt. St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Oct. (Month) 3 (Day), 188[illegible] (Year)

7-AGE: 38 yrs. 3 mos. 14 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Matthew Reardon

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine Mc Guire

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Reardon

(Address) 1232 Hull St.

15- Robert P. Harrison,

FILED JAN 18 1921, 191 — REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 17 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5 1920, to, Jan. 17 1921, that I saw her alive on January 13 1921, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), E. J. Bouchelle M. D.

1/17, 1921 [Address] 2104 St. Paul St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: Jan 21 1921

UNDERTAKER: Margaret D. Flynn — ADDRESS: 1722 Light St

Important. See instructions on back of certificate. It may be properly classified. Exact statement of OCCUPA-

D.49966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49966

CERTIFICATE OF DEATH.

92

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerardus Larsen

(Residence in Baltimore: No. 724 Edmonds St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1887 (Year)

7-AGE, 33 yrs. mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Cent Ry Co

9-BIRTHPLACE, (State or Country), Md

PARENTS:

10-NAME OF FATHER, Walter Larsen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Stull

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. F. Dash

(Address) Boarding House

15- Robert P. Harrison,

Filed ....., 191.. Burial Permit Clerk.

1/8/1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

3 dys (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 mos. yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Md | DATE OF BURIAL, Jan 18, 191..

20-UNDERTAKER M. F. Dashiell | ADDRESS Baltimore

See instructions on back of certificate. PHYSICIANS should state DISEASE EXACTLY. Exact statement of OCCUPATION is very important. It may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49967 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W. Saratoga ST.; 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Sneed

(a) RESIDENCE. NO. 505 W. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Don't know 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John T Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Haywood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Parker

(Address) 404 Shields Place

15 Filed JAN 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17-21 Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to Jan 16, 1921, that I last saw h alive on Jan 15, 1921, and that death occurred, on the date stated above, at eleven 17 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) J. Edward Fisher, M. D.

1-17 1921 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ent Auburn — DATE OF BURIAL: Jan 19 1921

20 UNDERTAKER: J. W. Skinner — ADDRESS: 1625 E. Madison St

...ic... ...be properly classified. Exact ...ent of OCCUPA... ...s on back of certificates.

D.49968 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49968

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersey Hospital St.: 4 WARD) 175-001

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Norman Weimert

(Residence in Baltimore: No. Westminster Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dont Know date (Month), (Day), 1913 (Year)

7-AGE, 8 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter Weimert

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Bankert

(Address) Westminster

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

N 18971

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or,~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull caused by Struck by automobile driven by David S. Rogers Washington D C

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

1-18, 1917 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Westminster Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westminster Md	1/21, 1917
20-UNDERTAKER	ADDRESS
H Bankert & son	Westminster Md

Be properly classified. Exact statement of OCCUPATION is very ... stated EXACTLY. PHYSICIANS should state ... may be ... instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.49969 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49969

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Broadway St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Mullen

(Residence in Baltimore: No. 305 N Broadway St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH. unknown (Month) (Day) 1831 (Year)

7-AGE. 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Lee

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Mullen

(Address) 205 W Belvidere Av

15- Jan 18 1921 Robert P. Harrison, 191 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1920 to Jan 17 1921, that I saw h[illegible] alive on Jan 2 1921 and that death occurred, on the date stated above, at 12 50 m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) G. C. Steele M. D.

1/17/21 (Address) 143 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL, Jan. 19.., 1921

20-UNDERTAKER Martin Fahey Sons

ADDRESS 1827 W North Av

Exact statement of OCCUPATION is very

D.49970 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.; 14 WARD) REGISTERED No. C 160

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Denny

(Residence in Baltimore: No. 1810 Madison St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, X (Month) D (Day), 1865 (Year)

7-AGE. 56 yrs. X mos. X ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... R.R. conductor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Penn. R.R. Co.

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Denny

(Address) 1345 W. Northern

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

JAN 18 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ovn

Laceration of arteries of neck (suicide)

(Duration) ....yrs....mos....1...ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. T. Hammann D. (Coroner.)

Jan. 18, 1921 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, ..., 19....

20-UNDERTAKER Martin Hughes & Son ADDRESS 1827 N. Northern

12-21.

...ly or properly classified. Exact statement of OCCUP... is very ...

...ions on back of certificate.

Cut with razor.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.49971

D.49971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3727 Roland Ave. ST.: 13 WARD)

2-FULL NAME Mary E. Redding

(a) RESIDENCE. No. 3727 Roland Ave. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Redding

6 DATE OF BIRTH (month, day, and year): April 6-1839

7 AGE: Years 81 | Months 9 | Days 11 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: Geo. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Catherine Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: Mrs. Clara M. Logsdon

(Address) 3727 Roland Ave

15 Filed JAN 18 1921, 19.....

Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to Jan 17, 1921, that I last saw h.. alive on Jan 17, 1921, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. 1½ ds.

CONTRIBUTORY (Secondary): Senile arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Reuais, M. D.

1/17, 1921 (Address) 865 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Balto. Co. Md.	Jan. 19 1921
20 UNDERTAKER: Horace Burgee & Son	ADDRESS: 3631 Falls Rd

(See instructions on back of certificate. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is required on certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49972 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49972

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Bush. St. 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna May Breen.

(a) RESIDENCE. No. 1003 Bush. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 14-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	00	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laber 040

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Rental

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Breen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Patrick Breen. (Address) 1003 Bush St.

Filed JAN 18 1921, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Jan 16, 1921, that I last saw her alive on Jan 14, 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 0 yrs. 00 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Raymond J. Blume, M. D.

, 19 (Address) Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 19 1921
20 UNDERTAKER	ADDRESS
Harry N. Witzke	531 S. Lond

Read instructions on back of certificate. Exact statement of OCCUPATIONS should state whether employer or employee, and if employee, whether skilled or unskilled. Unless these facts are properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.— 1006 Bks.

D.49973 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49973

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 W. Saratoga ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline (Put) Speer

(a) RESIDENCE. No. 739 W. Saratoga ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Speer.

6 DATE OF BIRTH (month, day, and year) Dec 19, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Carl Abkel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Abkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm G. Mueller.

(Address) 739 W. Saratoga St

15 Filed JAN 18 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1921, to Jan 17, 1921, that I last saw her alive on Jan 16, 1921, and that death occurred, on the date stated above, at 2.00 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of thyroid & mediastinum (duration) yr. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? ..... Date of No.

Was there an autopsy? No.

What test confirmed diagnosis? -

(Signed) Santana Pratt, M. D.

, 19 (Address) Cecelia.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 19 1921
20 UNDERTAKER	ADDRESS
Harry D. Witzke	1531 W. Fayette

May be properly classified. Exact statement of OCCUPATION. PHYSICIANS should state cause of certificates. See instructions on back of

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D.49974 HEALTH DEPARTMENT—CITY OF BALTIMORE D.49974

CERTIFICATE OF DEATH

28

1-PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Williams

(a) RESIDENCE. No. 1601 E. Preston ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 12/15/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25 years	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 109

(b) General nature of industry, business, or establishment in which employed (or employer) Office

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill (State or country) Worcester Co

PARENTS

10 NAME OF FATHER Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) Snow Hill (State or country) Worcester Co

12 MAIDEN NAME OF MOTHER V. Riley

13 BIRTHPLACE OF MOTHER (city or town) Snow Hill (State or country) Worcester Co

14 Informant Virginia Williams (Address) 1601 E. Preston st

15 Filed 1 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to Jan. 17, 1921, that I last saw her alive on Jan. 17, 1921, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows: DUE

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia - Th.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Dec. 11, 1920.

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) F. C. Marino, M. D.

1-17, 1921 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Snow Hill Cemetery Worcester Co	Jan. 19 1921

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford Ave

Be sure that all items are properly classified. Exact statement of OCCUPATIONS should state kind of work done in each. Fill in all items. For instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN:

Operation for intestinal obstruction. Adhesions.
Possibly T.B.C.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49975

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 N. Peare ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dearing

(a) RESIDENCE. No. 9 N. Peare ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Degring

6 DATE OF BIRTH (month, day, and year) 10/2/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Dearing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs M Dearing

(Address) No. 9. Peare st

15 Filed 1-18-1921 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Jan. 16, 1921, that I last saw him alive on Jan. 16, 1921, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Herbert S. Blake M. D.

, 19 (Address) 1014 W. La Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 19 1921

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hayford av

IMPORTANT: ... should be properly classified. Exact statement of OCCUPATIONS should state ... See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.49976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.49976

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Blacke

(a) RESIDENCE. No. 1642 Holbrook st ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 29th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Dedrick Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza J Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record (Address) J. H. H.

15 Filed ....., 19 Robert P. Harrison, Registrar

JAN 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17

I HEREBY CERTIFY, That I attended deceased from 1/11/21, 19..., to 1/18/21, 19..., that I last saw h... alive on 1/18/21, 19..., and that death occurred, on the date stated above, at 10:00 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? Yes.

What test confirmed diagnosis? Findings in lungs

(Signed) Edward C. Davidson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1/20 19

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave

PHYSICIANS should state exact statement of OCCUPATION. Every item of information may be properly classified. See instructions on back of certificates. Every item is important.

Spec.—6-9-13—H. P. Co.—1000 Bks.

049977

HEALTH DEPARTMENT—CITY OF BALTIMORE

049977

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Plum alley ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Woods

(a) RESIDENCE. No. 1023 Plum alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sarah Woods (Dead)

6 DATE OF BIRTH (month, day, and year) May-11-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Lab

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Woods

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Ann Ross

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Alice Grayson (Address) 1023 Plum alley

15 FILED JAN 19 1921 ROBERT E. KRAETER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1921, to Jany 16, 1921, that I last saw him alive on Jany 15, 1921, and that death occurred, on the date stated above, at 10 AM m.

The CAUSE OF DEATH* was as follows:

Pneumonia. 2

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) ovy

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. D. Smith, M. D.

, 19 (Address) 109 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Jan 19 1921
20 UNDERTAKER Samuel Hawley	ADDRESS 818 N Broadway

Be sure to be properly classified. Exact statement of OCCUPATION. PHYSICIANS should ... of certificates. See instructions on back of certificate. Important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pulmonary Tuberculosis.

Spec.—8-24-14—M. & T.—2000 Bks.

D49978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49978

CERTIFICATE OF DEATH.

29

REGISTERED NO. C.....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Weinstein

(Residence in Baltimore: No. 1223 E. Biddle St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1874
(Month) (Day) (Year)

7-AGE 47 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Weinstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin

(Address) 1411 E. Baltimore St

15-
Filed JAN 19 1921 ROBERT P. KRAUTER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 11 1921, to Jan 18 1921, that I saw her alive on Jan 18 1921, and that death occurred, on the date stated above, at 9:15A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Myocardial Degeneration
Mitral Stenosis
2
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Bruce Lake M. D.

Jan. 18, 1921. (Address) 11 Thorus Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 7 ds. In the State 20 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1223 E. Biddle St

19-PLACE OF BURIAL OR REMOVAL, Herring Run

DATE OF BURIAL, 1—19—21

20-UNDERTAKER Jack Levin

ADDRESS 1411 E. Balto

049979

HEALTH DEPARTMENT—CITY OF BALTIMORE

049979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1631 Cuba St. ST.: 24 WARD) 182

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Nonn.

(Residence in Baltimore: No. 1631 Cuba St.

17 ---------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, March 12th. 1876, 1
(Month) (Day) (Year)

7-AGE, 44 yrs. 10 mos. ---- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cementer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

083

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Nonn. (wife)

(Address) 1631 Cuba St.

15- JAN 19 1921 Filed....., 191.... ROBERT J. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 12th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autps & Inost (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage & laceration of the brain.
Pistol shot wound in the head.
Homicide.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

Otto K. Leonhardt M. D.
(Coroner.)

Jan. 18, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Jan 19 1921
20-UNDERTAKER John Herwig & Co	ADDRESS 2008 Eutaw.

Directions: Every question should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1049980 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049980

CERTIFICATE OF DEATH.

79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 592 Green Willow St. 17 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Peaker.

(Residence in Baltimore: No. 592 Green Willow St.; yrs. 72 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, September 15, 1875
(Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Washington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Peaker

(Address) 592 Green Willow St.

15- JAN 19 1921 ROBERT J. KRAUTER

Filed ....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophic heart disease

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 18, 1921. (Address) 2807 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Jan. 19, 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 143 Wilkens Ave

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. Any abbreviations that may be used may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

049981 HEALTH DEPARTMENT—CITY OF BALTIMORE 049981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 McCulloh St. ST.; 14 92 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Cann

(Residence in Baltimore: No. 2122 McCulloh St.; 61 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
femal	Colerd	married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 61 yrs. ... mos. ... ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 07

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, edurd merrell

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Linton

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) frank merrell

(Address) 2122 McCullough St.

15- Filed JAN 19 1921 191... ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Jan 17 1921, that I saw h.r alive on Jan 16 1921, and that death occurred, on the date stated above, at 4.30a m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Organic Disease

..... (Duration) ... yrs. ... mos. 7 ds.

(Signed) C. B. Flosen M. D.

Jan 17, 1921 (Address) 712 S. Wood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cem | DATE OF BURIAL, Jan 20 1921

20-UNDERTAKER John H. Toadvine | ADDRESS 142 Carroll St

Duty Enjoined. Exact statement of OCCUPATION is very ... PHYSICIANS should state ... of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L049982 HEALTH DEPARTMENT—CITY OF BALTIMORE L049982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Hollen Road, Govans ST.; 27 120 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Bruce Thompson

(a) RESIDENCE. NO. 404 Hollen Road ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Molly Pattison

6 DATE OF BIRTH (month, day, and year) June 10, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of Industry, business, or establishment in which employed (or employer) Metal Package Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Robert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Miss Sadie Thompson
(Address) 3732 York Road

15 Filed JAN 19 1921 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1921, to Jan 16, 1921, that I last saw h[illegible] alive on Jan 16, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis
Interstitial nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Colitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Gross, M. D.

18/1/21 (Address) 1508 Mt Royal Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/19, 1921
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son Co	N. Calvert

IMPORTANT. PHYSICIANS should state carefully and fully all facts required. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1049983

HEALTH DEPARTMENT—CITY OF BALTIMORE

1049983

CERTIFICATE OF DEATH.

63-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Old ST. 19 WARD)

2-FULL NAME Leslie McDonell Fall

(a) RESIDENCE. NO. 1731 Old ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. Every item of Information is important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8-1908

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
12	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Pitts
(State or country) Md

PARENTS

10 NAME OF FATHER John W. Fall

11 BIRTHPLACE OF FATHER (city or town) Pitts
(State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Jones

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co
(State or country) Md

14 Informant John W. Fall
(Address) 1731 Old Ave

15 Filed JAN 19 1921 ROBERT I. CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1920, to Jan 18, 1921, that I last saw h~~im~~ alive on Jan 18, 1921, and that death occurred, on the date stated above, at 12 25 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Progressive Spinal Muscular atrophy

(duration) 5 yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) F W Wenner, M. D.

1/18, 1921 (Address) 1302 N Longwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sp Lg Springs Cem Woodlawn Md

DATE OF BURIAL Jan 20 1921

20 UNDERTAKER F Stanley Gore

ADDRESS 1723 N Eutaw St

D49984 HEALTH DEPARTMENT—CITY OF BALTIMORE D49984

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Hanover & Henrietta Sts. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin J. Hartman.

(Residence in Baltimore: No. 811 S. Charles St. St.: 7 yrs., 4 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Single.

6-DATE OF BIRTH, August 19th. 1913., 1 (Month) (Day) (Year)

7-AGE, 7 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 100
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Adam Hartman.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Florence E. Smith.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence E. Hartman. (mother)

(Address) 811 S. Charles St.

15- Filed JAN 19 1921 191 ROBERT E. LEUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 15th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Crushed about the pelvis, having been having been run over by auto-truck No. 22313 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Jany. 18 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loraine Cemetery	Jan. 19, 1921
20-UNDERTAKER	ADDRESS
F. A. Frances & Son	703 Hanover St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49985 HEALTH DEPARTMENT—CITY OF BALTIMORE D49985

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N Biray ST.: 6 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert E. Mc. Claus

(a) RESIDENCE. No. 143 N Biray ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~Widow~~ of Mattie L. Mc. Claus

6 DATE OF BIRTH (month, day, and year) June 4/46

7 AGE: Years 75 — Months 7 — Days 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): — — 052
(c) Name of employer: — — —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John A Mc. Claus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Penn

12 MAIDEN NAME OF MOTHER: Ellen Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: John. E. Mc. Claus
(Address): 143 N Biray

15 Filed JAN 19 1921 ROBERT J. SLATER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/21

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920 to Jan 17, 1921, that I last saw h[illegible] alive on Jan 17 - 1921, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. 48 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

over

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam.

(Signed) Geo Clinton Bladen M. D.

1/18/21 (Address) 143 N Biray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: 1/19 1920

20 UNDERTAKER: John A. Moran

ADDRESS: 3000 E Balto

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION may be properly classified, so that it may be very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Interstitial Nephritis - No Hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D49986 D49986 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Stiles St. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pohler

(a) RESIDENCE. No. 1010 Stiles St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Pohler

6 DATE OF BIRTH (month, day, and year) May 12 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frank Pohler (Address) 1010 Stiles St.

15 Filed ..... 19 JAN 18 1921 Registrar

Coffey & 2303 N. Calvert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to Jan 18, 1921, that I last saw h[illegible] alive on Jan 17, 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Coffey, M. D.

, 19 (Address) 2303 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Jan. 20 1921
20 UNDERTAKER Wm Cook	ADDRESS W. Balto

FACT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 49987 — D 49987

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Monroe ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidonia F. Shenk

(a) RESIDENCE. No. 903 Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L Shenk

6 DATE OF BIRTH (month, day, and year) Dec 10 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Md

PARENTS

10 NAME OF FATHER Stephen Shenk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W Gary Shenk (Address) 903 Monroe St

15 Filed ... 19 JAN 19 1921 ROBERT J. [illegible] Registrar

Buried Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Jan 18 1921, that I last saw h-e alive on Jan 18 1921, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

(Address) 409 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Jan 20/21 1921

20 UNDERTAKER Wm. Cook ADDRESS 502 E. North ave

Embalmed.

Important. See instructions on back of certificates. PHYSICIANS should state ... may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49988

152

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Hanover ST. 23 WARD)

2-FULL NAME Mary E Cook

(a) RESIDENCE. No. 1117 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ened

6 DATE OF BIRTH (month, day, and year) Jan 6 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophia Zeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Cook
(Address) 1117 Hanover

15 Filed JAN 19 1921 19 ROBERT A KRAUTER Registrar
Social Parcel Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 18, 1921, that I last saw her alive on Jan 18, 1921, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Jan 21, 1921 (Address) 831 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Jan 19 1921

20 UNDERTAKER	ADDRESS
Wm Cook	808 E North

PHYSICIANS should state exactly. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

D49989 HEALTH DEPARTMENT—CITY OF BALTIMORE D49989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1127 Parrish ST. 23 WARD)

REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Giddings

(Residence in Baltimore: No. 1127 Parrish St. St.; yrs. 41 mos. ds.)

Should be stated EXACTLY. PHYSICIANS should write plainly in all terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, November, 1879
(Month) (Day) (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Oil Co.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, ? Giddings

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Johanna Curry

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Retyre Hart

(Address) 110 6 Parrish

15- ROBERT J. KRAUSE

Filed JAN 19 1921 191 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. S. Hammond M. D. (Coroner.)

Jan 19, 1921 (Address) 2502 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Edward Ave

19-PLACE OF BURIAL, OR REMOVAL Mt Auburn — DATE OF BURIAL, Jan 20, 1921

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 3d Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

049990 — 049990

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Fraction ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Silas Farrington

(a) RESIDENCE. No. 1402 Fraction ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? All his life ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Henry Farrington

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Blanche Lawson
(Address) 1402 Fraction St

15 Filed JAN 19 1921 ROBERT J. SLATER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1921, to Jan 14, 1921, that I last saw him alive on Jan 13, 1921, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) E. L. Stevens, M. D.

, 19 (Address) 704 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan 19 1921

20 UNDERTAKER: Edw. Quiggold — ADDRESS: 1463 Carey

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D49991

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S. Fourth St. ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Stephens

(a) RESIDENCE. No. 621 S. Fourth ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3, yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) Invalid.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Wrightson Stephens

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. H. Stephens (Address) 621 S. Fourth St.

15 JAN 19 1921 ROBERT A. KRUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1921, to Jan. 19, 1921, that I last saw h.. alive on Jan 19, 1921, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensency. —
Chronic Bronchitis. —

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Senile Debility. —

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination

(Signed) W. E. Hall, M. D.

Jan 19, 1921 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Cem. Dorchester Co Md.	Jan 22 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeile.	403 S. Wolfe

TION is very important. See instructions on back of certificates.

Henry J Zink

D49992 HEALTH DEPARTMENT—CITY OF BALTIMORE D49992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 79

CITY OF BALTIMORE (No. 316 Light St. St.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J Zink

(Residence in Baltimore: No. 316 S Light St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.)
Male	White	Widower

6-DATE OF BIRTH, March (Month) 18 (Day), 1857 (Year)

7-AGE 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer D.H.D.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER Engelbert Zink Sr.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary K Kuhn

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B Zink

(Address) 316 S Light St

15- FILED JAN 19 1921 191 ROBERT B KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clarence Engel M. D. (Coroner)

Jan 19, 1921 (Address) 1508 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan 21, 1921

20-UNDERTAKER J & J. Herr — ADDRESS 1562 W. Fayette

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is necessary. AGE should be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D49993 HEALTH DEPARTMENT—CITY OF BALTIMORE D49993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 9

CITY OF BALTIMORE: (No. 1511 Carrollton Ave St.) (WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dorothy Arnold

(a) RESIDENCE. NO. 1511 Carrollton Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Fifteen. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1918

7 AGE — Years: 2 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Schirlock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richard Arnold
(Address) 1511 Carrollton Ave B.

15 Filed JAN 19 1921 ROBERT I. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Jan 18, 1921, that I last saw h[illegible] alive on Jan 18, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm. H. Keefe, M. D.

, 19 (Address) 916 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 1/19 1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

PHYSICIANS should state EXACTLY. Exact statement of OCCUPA- may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 49994

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 D 49994

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Harwood ave Govans St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madison E Lloyd.

(Residence in Baltimore: No. Harwood ave Govans St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: Jan (Month) 6 (Day), 1872 (Year)

7-AGE: 49 yrs. 0 mos. 12 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Survey Er 042
(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate Dealer

9-BIRTHPLACE (State or country): Md,

PARENTS

10-NAME OF FATHER: Joshua E Lloyd.

11-BIRTHPLACE OF FATHER (State or country): Penna.

12-MAIDEN NAME OF MOTHER: Anna R. Erdman

13-BIRTHPLACE OF MOTHER (State or country): Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Madison Lloyd,

(Address) Govans,

15- [illegible] E KRAUTER

FILED JAN 19 1921 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan. (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1919, to Jan. 18 1921, that I saw him alive on Jan. 18 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Ureteral Sclerosis

(Duration) Many yrs. mos. ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) W. C. Hoen M. D.

Jan 19 1921. [Address] 5700 York Rd.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Presbyterian Cemetery Govans

DATE OF BURIAL: Jan 21, 1921

20-UNDERTAKER: Scott M Storr

ADDRESS: Edmondson Ave Md

Form is very important. See instructions on back of certificate. ... should be stated EXACTLY. PHYSICIAN ... may be properly classified. Exact statement of OCCUPA...

Spec.—6-9-19—H. P. Co.—1000 Bks.

№ 49995 HEALTH DEPARTMENT—CITY OF BALTIMORE № 49995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH N.E. Cor Baltimore & Hayson Sts 120

CITY OF BALTIMORE: (No. ~~Usual~~ German Aged & Infirm Home ST. 90 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Snead

(a) RESIDENCE. No. N.E. Cor Balto & Hayson ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jemima Snead.

6 DATE OF BIRTH (month, day, and year) Mar 14 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co (State or country) Va

PARENTS

10 NAME OF FATHER George F Snead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Henrietta Snead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records of German Aged Home (Address) N E Cor Balto & Hayson Sts

15 FILED JAN 19 1921 ROBERT V. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1920, to Jan 16th, 1921, that I last saw h... alive on Jan 15th, 1921, and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John E Snead, M. D.

19 . 1921 (Address) 1873 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 19 1921

20 UNDERTAKER J R Cook

ADDRESS 1003 W Balto St

It may be properly classified. Exact statement of OCC... on back of certificates.

...stated EXACTLY. PHYSICIANS should state ... Every item of infor... ...ary important. See instructions on ba...

1049996 HEALTH DEPARTMENT—CITY OF BALTIMORE 1049996

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2603 Bruce Terrace ST. 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth E. Morris

(Residence in Baltimore: No. 2603 Bruce Terrace St.; yrs., 1/6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	White	Single

6-DATE OF BIRTH, Dec 24, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~none~~
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Luther A Morris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lillian Morgan

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther A Morris

(Address) 2603 Bruce Terrace

15- JAN 19 1921 ROBERT E KRAUTER

Filed ....., 191.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mordasmus

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Lane Morrison M. D. (Coroner.)

Jan 19 1921. (Address) 232 Rotunda

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Jan 19 1921

20-UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

IMPORTANT should be stated EXACTLY. PHYSICIANS should make PRINT TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D~~ 49997 ~~1403~~ D 49997 45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip J. Rohr

(a) RESIDENCE. No 407 N. Stricker St. WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Rohr

6 DATE OF BIRTH (month, day, and year) Feb 25 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frederick Rohr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Tutwiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Hospital Record (Address) J. H. H.

15 Filed JAN 19 1921 [redacted] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 - 1920, to Jan 17 - 1921, that I last saw h... alive on Jan 17 - 1921, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Head of Pancreas

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. R. Mason, M. D.

Jan 18, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan 20 1921
20 UNDERTAKER	ADDRESS
Jos Saunders & Son	217 S. Paca St

THION is very important. See instructions on back of certificates.

...TH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

...should be stated EXACTLY. PHYSICIANS should state

...CERTIFICATE OF DEATH. Every item of infor-

D. 49998 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 49998

CERTIFICATE OF DEATH.

1168-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 E. Heath St. ST.: 24 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Carter Jr.

(Residence in Baltimore: No. 225 E. Heath St. St.: 29 yrs., 9 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Single

6-DATE OF BIRTH, April 3rd. 1891. (Month) (Day) , 1 (Year)

7-AGE,	If LESS than 1 day,
29 yrs. 9 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Oiler. D40
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John J. Carter Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Matilda Herd.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Carter Sr. (father)

(Address) 225 E. Heath St.

15- Robert P. Harrison,

19402 ....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 18th. 1921 (Month) (Day) , 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Accidental death.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto W. Bernard M. D.
(Coroner.)

Jany. 18, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London. Pk Cem	1/20. 19 21
20-UNDERTAKER	ADDRESS
S. Few McCully	130 E. Fort Ave

See instructions on back of certificate. ...AGE should be stated EXACTLY. PHYSICIANS should state ...terms, so that it may be properly classified. Exact statement of OCCUPATION is very ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.49999 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.49999

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Sydenham Hospital St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wade Corum

(a) RESIDENCE. NO. 118 N. Fremont St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wade F. Corum

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Md

12 MAIDEN NAME OF MOTHER Helena Dixon

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md

14 Informant Wade F. Corum (Address) 118 N. Fremont Ave

15 Filed 1 1921 Robert P. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1921, to Jan 19, 1921, that I last saw h[illegible] alive on Jan 18, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Chronic gastro-enteritis)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Diphtheria, nasal

(duration) yrs. mos. 7(?) ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultura.

(Signed) B Macgowan, M. D.

Jan 19 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 20 1921
20 UNDERTAKER	ADDRESS
Peter Jucolans	2046 Eas

It may be properly classified. Exact statement of OCCUPATION should be stated on back of certificates.

Items are very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50000 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50000

CERTIFICATE OF DEATH.

9r

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S Mount St., 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry O McLavell

(a) RESIDENCE. No. 723 S Mount St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie McLavell

6 DATE OF BIRTH (month, day, and year) unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm McLavell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Johanna McLavell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

Informant (Address) Katherine McLavell 1205 E Madison Ave

JAN 19 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 18, 1921, that I last saw h.sw alive on Jan 18, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 723 S Mount St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Thomas Nelson, M. D.

, 1921 (Address) 1001 S Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 20 1921
20 UNDERTAKER W. J. Tuckwell Sons	ADDRESS North

It may be properly classified. Exact ... of OCCUPA-

... important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50001 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50001

CERTIFICATE OF DEATH.

105

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2930 Huntingdon Ave St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mallissa Lopez

(Residence in Baltimore: No. 2930 Huntingdon Ave St.; 17 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Apr. 9, 1836 (Month) (Day) (Year)

7-AGE, 84 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Invalid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William H Jones

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Deanna Downes

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Justice

(Address) 2930 Huntingdon Ave

15- Robert P. Harrison,
Dated JAN 19 1921, 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Jan 17 1921, that I saw h s alive on Jan 17 1921, and that death occurred, on the date stated above, at 3.0 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhoea

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

..... (Duration) yrs. 2 mos. ds.

(Signed) C L Norment M. D.

Jan 19, 1921. (Address) 3542 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, ..., 191..

20-UNDERTAKER A S Marshall ADDRESS 3539 Fait Rd

Instructions on back of certificate. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50002 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50002

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. #2400 N. Charles St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minna Eudora Starr.

(a) RESIDENCE. No. 2400 N. Charles St. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 1 ds. How long in U. S., If of foreign birth? 72 yrs. 4 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Starr.

6 DATE OF BIRTH (month, day, and year): Sept-17-1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Robert M. Croxall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Sarah Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland.

14 Informant: Mrs. Agnus S. Bayley (daughter)
(Address) Monkton, Balto Co., Md.

15 Filed ..... 19.....
Robert F. Harrison,
Registrar
NI 91921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920, to January 17th 1921, that I last saw h[er] alive on January 17th 1921, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Arthritic Rheumatism
with a Nephritic Complication

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Immediate cause of death
Uraemic Coma (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —,

Was there an autopsy? No — Albumen

What test confirmed diagnosis? Urine Contained blood

(Signed) Geo H Cairnes, M. D.

, 19 (Address) 21 W 28th Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan-20- 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)
ADDRESS: 108 W. NORTH AVE.

NOTE—Items must be stated EXACTLY. PHYSICIANS should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50003 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50003

CERTIFICATE OF DEATH.

x 69

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Brown

(a) RESIDENCE. No. Keyser, W Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Frank R. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va.

12 MAIDEN NAME OF MOTHER Ethel Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Hospital Record
(Address) J. H. H.

15 Filed Robert P. Harrison, Registrar

191921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Jan 19, 1921, that I last saw her alive on Jan 19, 1921, and that death occurred, on the date stated above, at 12 M. P. m.

The CAUSE OF DEATH* was as follows:

Respiratory failure following Craniotomy for epilepsy.

OVER

(duration) 7 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Operative (2½ hrs)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? Yes Date of Jan. 17 20.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harry J. Plath. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keyser W Va	Jan 19 19

20 UNDERTAKER H E Myers ADDRESS 424 N. Broadway

THIS IS very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Wasserman negative.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50004

CERTIFICATE OF DEATH.

37

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 McCulloh. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roswell G. Harris

(a) RESIDENCE. No. 926 McCulloh. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Annie Crafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn N.Y.

14 Informant Annie Crafford

(Address) 926 McCulloh St

15 Filed JAN 20 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18- 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-18-, 1921, to 1-18-, 1921, that I last saw him alive on 1-18-, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M H Garnett, M. D.

20-1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Mt. Auburn Cem Jan 20 1921

20 UNDERTAKER Samuel Hensley Middle ADDRESS 578

...ATION is very important. See instructions on back of certificates.

...should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Blks.

050005 HEALTH DEPARTMENT—CITY OF BALTIMORE 050005

CERTIFICATE OF DEATH.

Tupelo Page 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Gladstone ST.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hamm

(Residence in Baltimore: No. 720 Gladstone, St.; 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 23, 1853 (Month) (Day) (Year)

7-AGE, 67 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Hamm

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Asked Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Asked Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Hamm

(Address) 720 Gladstone Ave

15- Filed JAN 20 1921, 191.... ROBERT J. KRAUTH Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan- 1914, to Jan 18 1921, that I saw h inalive on Jan 18 1921, and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Flow of two Previous Hemor-

Rages (Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senile Cerebral Arteriosclerosis

Cause (Duration) 7 yrs. 7 mos. ds.

(Signed) M. Alan Porter M. D.

Jan. 19, 1921. (Address) 422 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 21, 191...

20-UNDERTAKER A. S. Marshall — ADDRESS 353 Park Ave

May be properly classified. Exact statement of OCCUPATION is very ... EXACTLY. PHYSICIANS should state ... on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50006 D50006

CERTIFICATE OF DEATH.

154

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 W. 33 St ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Loftus

(Residence in Baltimore: No. 600 W. 33d St St.; 74 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, December (Month), (Day), 1834 (Year)

7-AGE 86 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Loftus

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Loftus

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm F. Expt

(Address) 600 W. 33 St

15- Filed JAN 20 1921, 19.. SOLEY & KRAUTER Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 19 1921, that I saw h.. alive on Jan 19 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Contributory Lombard

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Kownacki M. D.

Jan 20, 1921. (Address) 2343 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Jan 22 1921

20-UNDERTAKER A S Marshall ADDRESS 2539 Fall Ky

IMPORTANT: AGE should be stated EXACTLY. PHYSICIANS should state disease so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050007

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Potomac Ave ST. Brooklyn 25 WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Wright Morris

(a) RESIDENCE. No. 400 Potomac Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Blanche Morris

6 DATE OF BIRTH (month, day, and year) Oct 30 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	19	

8 OCCUPATION OF DECEASED 018

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) of the Gospel

(c) Name of employer

9 BIRTHPLACE (city or town) Woodstock
(State or country) Bullitt Co Ky

PARENTS

10 NAME OF FATHER Rev. R. Scott Morris

11 BIRTHPLACE OF FATHER (city or town) Bullitt Co
(State or country) Ky

12 MAIDEN NAME OF MOTHER Julia Wright

13 BIRTHPLACE OF MOTHER (city or town) Carlisle
(State or country) Pennsylvania

14 Informant Mrs. Blanche Morris
(Address) 400 Potomac Ave Brooklyn

15 Filed ..., 19 ...

JAN 20 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan ..., 19 21, to Jan 18, 19 21,

that I last saw him alive on Jan 17, 19 21,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis -
Arterio-Sclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Ex Lues

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Broode, M. D.

Jan 19 21 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK.	JAN 20 1921 19
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

THION is very important. See instructions on back of certificates. ... in plain terms, so that it may be properly classified. Exact statement of OCCUPA... ...ould be stated EXACTLY. PHYSICIANS should write ... ...ORD. Every item of infor...

Spec.—8-24-14—M. & T.—2000 Bks.

D50008 HEALTH DEPARTMENT—CITY OF BALTIMORE D50008

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 S. Bond St.; 3 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Graff

(Residence in Baltimore: No. 222 S. Bond St.; 1 yrs., 2 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, October (Month) 22 (Day), 1919 (Year)

7-AGE, 1 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0"0

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Raymond R Graff

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Catherine Ghirardello

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond R Graff

(Address) 222 S. Bond St

15 JAN 20 1921 ROBT. J. KRAUTER Registrar.
Filed....., 191.....
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 18th (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jany 16 1921, to Jany 18 1921, that I saw h[illegible] alive on January 18 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 6 d

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Spasmus

(Duration) ....yrs. ....mos. ....ds.

(Signed) F W Brown M. D.

Jany 18, 1921 (Address) 1928 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Jan 20th, 1921

20-UNDERTAKER Lilly & Julen — ADDRESS 403 S. Wolfe St

Be properly classified. Exact statement of OCCUPATION is very ... that it may be ... instructions on back of certificate. ... stated EXACTLY. PHYSICIANS should also ... RECORD

Remarks No other infection other than heavy cold.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50009 D50009

REGISTERED NO. C 3 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S. Spring st ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lesley Henson

(Residence in Baltimore: No. 212 S Spring st, St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, November 27, 1904
(Month) (Day) (Year)

7-AGE, 16 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Garret Henson

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Lilly Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Johnson

(Address) 212 S. Dallas St.

15-Filed JAN 20 1921 191. ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 19, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Jan 18 1921, that I saw him alive on Jan 18 1921, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Richard Eastman M. D.

Jan 19, 1921 (Address) 1514 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Arbury	Jan 22, 1921
20-UNDERTAKER John C Henderson	ADDRESS 1503 Edmondson

Be properly classified. Exact statement of OCCUPATION is very important. Fill out all items. Physicians should state CAUSE OF DEATH correctly and fully. Undertakers must see that certificate is filled out EXACTLY. PHYSICIANS

Spec.—6-9-19—H. P. Co.—1000 Bks.

50010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50010

CERTIFICATE OF DEATH.

REGISTERED NO. 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Colbert

(a) RESIDENCE. NO. 322 Calvin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) November 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) none 000

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Georgie Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Georgie Wolford

(Address) 322 Calvin St

15 Filed JAN 20 1921 ROBERT F. KRAUTER Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to Jan 17, 1921, that I last saw her alive on Jan 17, 1921, and that death occurred, on the date stated above, at 2 10 P m.

The CAUSE OF DEATH* was as follows:

acute Parenchymatous Nephritis

000

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Martindale, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan 20 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

IMPORTANT RECORD. Every item of information must be stated EXACTLY. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diagnosis based on autopsy. No other abnormal condition known to Dr. Martindale.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50011

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Foster Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Ey

(Residence in Baltimore: No. 2316 Foster Ave St.; 56 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) ..... (Day), 1864 (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 003

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Fred Ey

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorlsmon

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. G. Moran

(Address) 3000 E. Baltimore St.

15-

Filed JAN 20 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 17th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1920, to Jan 17 1921, that I saw h[illegible] alive on [illegible] 16 1921, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Hess M. D.

1921, 191... (Address) 408 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Int. Laurel Cem. DATE OF BURIAL, 1-20, 1921

20-UNDERTAKER J. G. Moran ADDRESS 3000 E. Baltimore

...ay be properly classified. Exact statement of OCCUPATION is ...

...ions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50012 HEALTH DEPARTMENT—CITY OF BALTIMORE D50012

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homat Hom Refuge ST., 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Zelockewski -

(a) RESIDENCE. No. 719 Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Don't Know yrs. Don't Know ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mrs Zelockewski

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	34	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedor

(b) General nature of industry, business, or establishment in which employed (or employer) Loading Ships -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know Russia -

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Suppose Russia -

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Suppose Russia

14 Informant Records of Mt Hope Refuge (Address) Mt Hope Md -

15 Filed JAN 20 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1921

17

I HEREBY CERTIFY, That I attended deceased from June 3rd 1920, to Jan 19, 1921, that I last saw him alive on Jan 18th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coreas - (R. Hemiplegia / Specific -

abt (duration) 1 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Paralytica -

abt (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W. Test -

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Refuge -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	1/21/21
20 UNDERTAKER	ADDRESS
Wm F Kaufmann	1610 E

IMPORTANT. See instructions on back of certificates. Every item of information should be stated EXACTLY. PHYSICIANS should state exact terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important.

D 50013 HEALTH DEPARTMENT—CITY OF BALTIMORE D 5001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1306 Stockton St St.; 15 WARD)

REGISTERED No. C 91

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Johnson

(Residence in Baltimore: No. 1306 Stockton St St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 4, 1920
(Month) (Day) (Year)

7-AGE, yrs. 4 mos. 15 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Solomon Johnson

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Isabella Garrett

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Mrs. Sol. Johnson
(Informant)

(Address) 1327 Park Ave

15 JAN 20 1921 ROBERT P. LEA
Filed ..... 191.. Assistant
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. Hennessy M. D.
(Coroner.)

Jan. 19 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Jan 20th, 1921

20-UNDERTAKER Garrett Funeral Home

ADDRESS 1364 Caroline

See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-500014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-500014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4704 Eastern Ave ST.; 26 WARD)

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Mason Kane

(a) RESIDENCE. NO. 313 S. Clinton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 28/20

7 AGE: Years — Months: 5 — Days: 22 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Thos. Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cora Vinyard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Cora Kane

(Address) 4704 Eastern

15 Filed JAN 20 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1921, to Jan 19th, 1921, that I last saw him alive on Jan 19th, 1921, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 313 S Clinton St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: Jan 20 1921

20 UNDERTAKER: Philip Henrig — ADDRESS 2016 Aliceanna

IMPORTANT.—Every item of information should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 500 15

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 500 15

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Riggs Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Blunt

(a) RESIDENCE. No. 1100 Riggs Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Edward Blunt

6 DATE OF BIRTH (month, day, and year) Unknown 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59.	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Anthony Lanthier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Edenton N C

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Peter Lanthier (Address) 1110 Riggs Ave

15 Filed JAN 20 1921 ROBERT B. [illegible] Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1921, to January 17, 1921, that I last saw h[illegible] alive on January 17, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Myocarditis Chr.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas P Lanahan M. D.

Jan 30 1921 (Address) 1504 Mahool Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 21 1921
20 UNDERTAKER	ADDRESS
Sam W. Crane Jr	140 Mosher

Very important. See instructions on back of certificate. ... be stated EXACTLY. PHYSICIANS should state ... may be properly classified. Exact statement of OCCU... ... plain terms, so that it may be ... CERTIFICATE OF DEATH. Every item of infor...

Spec.—8-24-14—M. & T.—2000 Bks.

D50016 HEALTH DEPARTMENT—CITY OF BALTIMORE D50016

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 N. Carey ST.; 18 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delia M. Stansfield

(Residence in Baltimore: No. 7 N. Carey St St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Sep 23d, 1863 (Month) (Day) (Year)

7-AGE, 57 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Levy Marr

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza Habbersett

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sally M. Stansfield

(Address) Dansrd Md

15- ROBERT P. LAMBERT

Filed JAN 20 1921 191. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 20th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Jan. 20 1921, that I saw h[illegible] alive on Jan. 19 1921, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastasis

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Benj. Lowdon M. D.

Jan 20, 1921 (Address) 2521 N. Ch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt View Md	1/22/21, 191...
20-UNDERTAKER	ADDRESS
Jas P Weer	Sykesville, Md

Please write plainly. Information required should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050017 HEALTH DEPARTMENT—CITY OF BALTIMORE 050017

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Vine ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Hawkins

(a) RESIDENCE. NO. 1043 Vine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col'd	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Coalbut, Jeduat

11 BIRTHPLACE OF FATHER (city or town) (State or country) county.

12 MAIDEN NAME OF MOTHER Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant C Hawkins
(Address) 1018 Vine st

15 Date received JAN 20 1921

ROBERT A. CRAIG
Registrar of Vital Statistics
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Jan 18, 1921, that I last saw h alive on Jan 5, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Norwood, M. D.

Jan 1, 19 (Address) 937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 20 1921
20 UNDERTAKER	ADDRESS
Felix B Pyle	102 E Fulton

IMPORTANT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50018 HEALTH DEPARTMENT—CITY OF BALTIMORE D50018

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3028 E. Monument ST. WARD) REGISTERED No. C

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bell Grimes

(Residence in Baltimore: No. 3028 E. Monument St.; yrs., mos. d

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Widowed

6-DATE OF BIRTH, May 23, 1867
(Month) (Day) (Year)

7-AGE, 53 yrs. 9 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jno McGee

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella McGee

(Address) 3028 E Monument St

15- FILED JAN 20 1921 191 ROBERT B KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed) [illegible] M.
(Coroner.)

1-19.., [illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents, DATE OF BURIAL Jan 22, 19

20-UNDERTAKER Eg J Manning & Son ADDRESS 1938 E Lafayette

IMPORTANT. See instructions on back of certificate. PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec. 6-9-19—B. P. Co.—1000 Bks.

1050019

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050019

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2128 E. North Ave. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Nicklas.

(a) RESIDENCE. No. 2128 E. North Ave. ST., WARD.

(Usual place of abode) Lifetime. (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Nicklas.

6 DATE OF BIRTH (month, day, and year) Apl. 29/1855.

7 AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Edward F. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Julia Rattle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Edward Ramsay.

(Address) 2229 W. Fayette St.

15 JAN 20 1921 BOARD OF HEALTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 19, 1921, that I last saw h[illegible] alive on Jan 19, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Glycosuria

(Signed) W. S. Flemming, M. D.

Jan., 1921 (Address) 1301 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Jan. 22, 20

20 UNDERTAKER Chas F. Ward & Son ADDRESS 118 W. Mt. Royal Ave.

FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly coded. EMPLOYMENT should state TION is very important. See instructions on back of certificates.

WRITE PLAINLY. USE PENCIL OR RED INK—THIS IS A LEGAL DOCUMENT AND MUST BE KEPT CLEAN AND UNMUTILATED. ALL RIGHTS RESERVED BY THE STATE OF MARYLAND.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50020 HEALTH DEPARTMENT—CITY OF BALTIMORE D50020

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Alhambra Apts ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Widdman

(a) RESIDENCE. NO. Lake Drive ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie C. Widman

6 DATE OF BIRTH (month, day, and year) Feby 7th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) 038

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Ignatz Widman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Amalia Bey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs Widman (Address) Alhambra Apts

15 FILED JAN 20 1921 ROBERT A. BEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from 14th Oct. 1920 to Jan 18 1921, that I last saw him alive on Jan. 18, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) L. J. Feldman, M. D.

, 19 (Address) 1921 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Jan 21st 1920

20 UNDERTAKER Paul Goudreau ADDRESS 18 N Mt Roy Ave

Uricoechea

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50021 D50021

CERTIFICATE OF DEATH.

X40

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. Louis J. Uricoechea.

(Residence in Baltimore: No. 1418 Eutaw Place. St.; ...yrs., 1 mos. 0 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 20 (Day), 1858 (Year)

7-AGE, 62 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), Colombia, South America.

PARENTS.

10-NAME OF FATHER, Juan Angustin Uricoechea

11-BIRTHPLACE OF FATHER (State or Country), Colombia South America.

12-MAIDEN NAME OF MOTHER Gaboca Cuellar

13-BIRTHPLACE OF MOTHER (State or Country), Colombia, South America.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luis Carlos Gabiria

(Address) Colombia - South America

15- JAN 20 1921 ROBERT J KRAUTER

Filed....., 191. Burial Permit Issued... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Jan 20 1921, that I saw h.m alive on Jan 20 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cascinoma of stomach.

(Duration) ...yrs. 6 mos. ...ds.

CONTRIBUTORY (Secondary) None

(Duration) ...yrs. ...mos. ...ds.

(Signed) Robert J Nuckee M. D.

Jan. 20, 1921. (Address) 1416 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. 2 mos. 0 ds. In the State ...yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bogota, Colombia, S.A.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 1-21, 1921.

20-UNDERTAKER Chas J. Waughlow ADDRESS N. Mt Royal ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50022 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50022

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Church Home & Infirmary 11 WARD)

2-FULL NAME James G. Stanley

(a) RESIDENCE. No. University Club ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. J. G. Stanley

6 DATE OF BIRTH (month, day, and year) July 20 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Wholesale druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant (Address) son (Ed. S. Stanley) 2187 W. Lanvale St

15 Filed JAN 20 1921, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921, to Jan. 18 1921, that I last saw him alive on Jan. 17 1921, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency 1 over

many (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. McGlannan, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Jan 20th 1921

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Eutaw

D.50023 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50023

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 841 Raborg ST. 18 79 WARD) REGISTERED No. C

2-FULL NAME Henry Lancroler

(Residence in Baltimore: No. 841 Raborg St.) (If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

St. 8 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Jones

(Address) 1387 Lemon

15- JAN 20 1921 Robert P. Harrison, ..., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 19, 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

..... (Duration) ..... Dont Know

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. ..... mos. ..... d.

(Signed) W K Jones M. D. (Coroner.)

1-20..., 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 21, 19

20-UNDERTAKER Brown & Freeland — ADDRESS 114 Schroeder

D. 50024 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50024

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

177

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 24 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Alton

(Residence in Baltimore: No. 211 E. Cross St.

St.; 3 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	black	Single

6-DATE OF BIRTH, ..., 1902
(Month) (Day) (Year)

7-AGE, 18 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman Fireman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jno Alton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Nettie King

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jno. Alton

(Address)..... 211 E. Cross

15- JAN 20 1921 Robert P. Harrison, 191 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Jan. 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull caused by accidentally falling from platform at 11th & Clement Sts

(Duration)..... yrs..... mos.....

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs..... mos.....

(Signed)..... M. D.
(Coroner.)

Jan 19, 1921 (Address)..... 1039 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
Mt. Harmony Cem., Gabrels & Co., Md	Jan. 21, 19
20-UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Eyler

Spec.—8-24-14—M. & T.—2000 Blks.

D. 50025 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50025

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 29 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Vieshon

(Residence in Baltimore: No. 4015 Gorsuch Oak Ave St.: 35 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 7 (Day), 1857 (Year)

7-AGE, 54 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard Vieshon.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary M. Thill.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Vieshon

(Address) 4015

15- JAN 20 1921 Registered

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to January 18 1921, that I saw h[er] alive on Jan. 18 1921, and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension
Chronic Diffuse Nephritis
(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy
(Duration) yrs. 6 mos. ds.

(Signed) Mary M. Thill M. D.
Jan. 18, 1921 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4015 Gorsuch Oak Ave

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Jan. 21, 1921

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50026 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50026

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Weinberg

(a) RESIDENCE. NO..... ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or — min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Oscar Weinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Margaret Mayo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Virginia

14 Informant Oscar Weinberg

(Address) 3004 Gryson St

15 Filed JAN 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from January 19th 1921, to January 19th 1921, that I last saw h— alive on January 19th 1921, and that death occurred, on the date stated above, at 10:00 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Eclampsia (1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan 19, 1921

Was there an autopsy? no

What (est confirmed diagnosis? same

(Signed) J. Morris Brage, M. D.

Jan 19, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Jan 20 1921
20 UNDERTAKER	ADDRESS
Leo G. Cook	Forest Park Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50027

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1323 n chapel St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Redd

(Residence in Baltimore: No. 1323 n Chapel St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, Col | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, Sept 25th, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). W

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Lewis Redd

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Louise Fultz

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Redd

(Address) 1323 n Chapel St

15- Robert P. Harrison,

JAN 20 1921, 191.... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the dny stated above.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

1-20, 21, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery | DATE OF BURIAL, Jan. 21, 1921

20-UNDERTAKER Wm. Rolta Elliott | ADDRESS, 725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D.50028 HEALTH DEPARTMENT—CITY OF BALTIMORE D50028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Glenwood Ave St. 27 28 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle Hall Walker

(Residence in Baltimore: No. 518 Glenwood Ave St.; 41 yrs., 5 mos. 5 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Aug (Month) 13 (Day), 1879. (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 5 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jno Odell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabelle Hall Walker

(Address) 518 Glenwood Ave

15-

Filed....., 191.... Robert P. Harrison, Registrar.

JAN 20 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Jan 18 1920, that I saw h[er] alive on Jan 17 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno C Rochling M. D.

Jan 19., 1920 (Address) 5835 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Zion Grave	Jan 21., 1920
20-UNDERTAKER	ADDRESS
Mrs Robt Parrott	Carlton Ave

Spec. 6-9-19 H. P. Co.—1000 Bks.

D.50029 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 15-28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tucker Hall

(a) RESIDENCE. NO. ~~Unknown~~ 1307 Presstman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Baltimore~~, Essex Co. ~~Maryland~~ Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 20 1921, 19 Registrar Robert T. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1921 to January 17, 1921 that I last saw him alive on January 17, 1921 and that death occurred, on the date stated above, at 5:40 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous osteitis, lumbar spine (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum examinations

(Signed) B. Stedman, M. D.

1/18/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stoney Creek Essex Co Va	Jan 21 1921

20 UNDERTAKER James A Davis ADDRESS 1303 Presstman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50030 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Freda Ave. ST. Lauraville WARD 27)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Bowers

(a) RESIDENCE. No. 105 Freda Ave. ST. Lauraville WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Bowers

6 DATE OF BIRTH (month, day, and year) Feb. 29th 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Truck

(c) Name of employer Own Farm

9 BIRTHPLACE (city or town) (State or country) Unknown Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs. Annie E. Bowers (Address) 105 Freda Ave. Lauraville

15 Filed JAN 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1920 to Jany 18, 1921, that I last saw him alive on Jany 18, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cetronic Myocarditis

(duration) — yr. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1/20, 1921 (Address) Hamilton-Baltimore-Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilson M. E. Cemetery	Jan. 21 1921
20 UNDERTAKER	ADDRESS
Fredk Lossadmr Son	Fullerton Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50031

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 432 East 21st St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Wright

(a) RESIDENCE. No. 432 East 21st ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Wright

6 DATE OF BIRTH (month, day, and year): aug 28 1889

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Brintead

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret O'neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret Lynch
(Address) 432 E. 21st

15 JAN 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20, 19 19, to Jan 18, 19 21, that I last saw h[er] alive on Jan 17, 19 21, and that death occurred, on the date stated above, at 1040 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ——— (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) John J. Feick, M. D.

Jan 19 21 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Jan 21 1921

20 UNDERTAKER: McClain Coale — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Heed 936-East Monument 5742 Mt Vernon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50032 ~~145324~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50032

CERTIFICATE OF DEATH.

X 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria Nye

(a) RESIDENCE. No. 5204 - 38th St N. W. ST., WARD. Washington D.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Simon L. Nye

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Juanita Kaufman

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant J. H. Hospital Records
(Address)

15 Filed JAN 20 1921 Robert ... (illegible)
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 20, 1921, that I last saw h.. alive on Jan 20, 1921, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) W. C. Davison, M. D.

1-20, 1921 (Address) J. H. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Jany 20 1921

20 UNDERTAKER ADDRESS

J C Mitchell 1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.50033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50033

CERTIFICATE OF DEATH.

79 Stansbury

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Falls Road ST.; Mt. Washington 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard N. Stansbury

(Residence in Baltimore: No. Falls Road, Mt. Washington St.; 1 yrs., — mos. 19 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 3, 1846 (Month) (Day) (Year)

7-AGE, 74 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer): 075

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, Josiah Stansbury

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co. Md

12-MAIDEN NAME OF MOTHER Appalona Null

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer E. Stansbury

(Address) Mt. Washington

15- JAN 20 1921

Robert F. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany. 19, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1920, to Jany. 19 1921, that I saw him alive on Jany 19 1921, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

acute Cardiac dilatation & decompensation

3 1/2 hours

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) Sherman R. Ward M. D.

1/19, 1921 (Address) 865 N. 30th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Zion (Fruelands, Balto Co) DATE OF BURIAL, Janu. 21 1921

20-UNDERTAKER Horace Burgee & Son ADDRESS 363 Falls Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145-631
D.50034

D.50034

54

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wagner

(a) RESIDENCE. NO. 1819 Hanover st ST. City WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? 40 yrs. 2 mos. 18 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Wagner (wife)

6 DATE OF BIRTH (month, day, and year) Mar. 3. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	2	18	

8 OCCUPATION OF DECEASED

086

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) American

(c) Name of employer Can Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kasler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. H. Hospital Records

15 Filed JAN 20 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 20, 1921, that I last saw h.. alive on Jan 20, 1921, and that death occurred, on the date stated above, at 12:00 A m.

The CAUSE OF DEATH* was as follows:

Acute Anaemia (pernicious ?)

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry H. Thomas Jr. M. D.

1-20, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Olivet Cem Jan 22 1921

20 UNDERTAKER — ADDRESS

Wm Cook 502 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

John J. Wood

D 50035 HEALTH DEPARTMENT—CITY OF BALTIMORE 165 0035

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH (use the words)

CITY OF BALTIMORE (No. Howard St. near Madison ST. 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Wood

(Residence in Baltimore: No. 1636 Ellamont St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, August 2, 1864
(Month) (Day) (Year)

7-AGE, 56 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 066
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... (dry goods)

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Chas. Wood

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Columbia Wheeler

13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Wood Jr.

(Address) 1636 Ellamont St.

15- JAN 21 1921 [illegible]
Filed....., 191.... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Left Kidney
10 months
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.

(Signed) T. Hennessy M. D.
(Coroner.)

Jan 21, 1921 (Address) 2807 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Howard St. near Madison St.

Former or usual residence 1636 Ellamont St.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Jan 21, 1921
20-UNDERTAKER	**ADDRESS**
J Ahlers & Co	1611 Mad

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50036

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 St. & 4th Ave., Fairfield ST.; 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Galbreath

(a) RESIDENCE. NO. 1421 St. & 4th Ave., Fairfield ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Howard W. Garrett

11 BIRTHPLACE OF FATHER (city or town) Brooklyn
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary D. Johnson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.,
(State or country) Md.

14 Informant Mary D. Johnson
(Address) 1106 Columbia Ave, Atlantic City, N.J.

15 Filed JAN 21 1921 19 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1920, to Jan. 18, 1921, that I last saw h.. alive on Jan. 18, 1921, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo B. Davis, M. D.

1/19, 1921 (Address) 211 Church St., Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	1-21 1921
20 UNDERTAKER	ADDRESS 142 W Fayette St
John A. Tradin	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50037 HEALTH DEPARTMENT—CITY OF BALTIMORE D50037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Argyle ST.; 17 WARD)

REGISTERED No. C 50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lewis

(Residence in Baltimore: No. 1206 Argyle St.; 50 yrs., mos., ds.)

N. B.—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1857 (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Albert

(Address) 206 Argyle Ave

15- JAN 21 1921 ..... 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/1, 1921, to 1/19, 1921, that I saw her alive on 1/16, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis, Chronic Nephritis

Gangrene of right foot up

to arm 3 days (Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

1/20, 1921 (Address) 221 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Jan 21, 1921

20-UNDERTAKER John N Soadin — ADDRESS 142 Ostend St

Spec.—6-9-19—H. P. Co.—1000 Blks.

050038

HEALTH DEPARTMENT—CITY OF BALTIMORE

050038

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 W. Hamburg ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Jackson

(a) RESIDENCE. No. 220 W Hamburg ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grant Jackson

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 037

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grant Jackson

(Address) 220 W Hamburg St

15 Date JAN 21 1921 BURIAL PERMIT ISSUED Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18/ 1921

17

I HEREBY CERTIFY, That I attended deceased from 1/15/ 1921, to 1/18/ 1921, that I last saw her alive on 1/18/ 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sub-acute nephritis about 2 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

1/19/ 1921 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	Jan 22 1921
20 UNDERTAKER	ADDRESS
C L Bromwell Son	1514 W Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50039 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D50039

29

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Sharp ST.: 27 WARD)

2-FULL NAME Jerome Rainey

(a) RESIDENCE. No. 619 S. Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) May 31st 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2 yrs	7 mos.	19 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (child)

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Saml Rainey

11 BIRTHPLACE OF FATHER (city or town) Georgetown (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Harriet Daniels

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Harriet Rainey (mother) (Address) 619 S. Sharp St.

15 FILED JAN 21 1921 ROBERT I. LEANTER Registrar Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th 1921, to Jan 19th 1921, that I last saw him alive on Jan 18th 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(duration) several weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) D. F. Carvell, M. D.

1/20, 1924 (Address) 1400 N. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Jan 21 1924

20 UNDERTAKER L. L. Brown's Son ADDRESS 108 W. Monty St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

L 50040

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 50040

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Mosher ST.: 16 WARD)

2-FULL NAME William Clarence Ausler

(a) RESIDENCE. No. 1113 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian D Ausler

6 DATE OF BIRTH (month, day, and year) June 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Curtis S. Ausler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Lillian Ausler (Address) 1113 Mosher St

15 Filed JAN 21 1921 ROBERT I. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Jan 20 1921, that I last saw him alive on Jan 19 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Hubert S Blake, M. D.

1/20, 1921 (Address) 10 14 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 22 1921

20 UNDERTAKER Wm J Tustin & Son ADDRESS Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50041

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S. Fremont ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophie Budcka

(a) RESIDENCE. No. 616 S. Fremont Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Budcka.

6 DATE OF BIRTH (month, day, and year) May 25, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	20 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Susie Gordon
(Address) 1133 Hamburg St

15 Filed JAN 21 1921 ROBERT B. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1920, to Jan. 20, 1921

that I last saw h alive on Jan. 19. 1921

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cyphosis of Cervic-
(hypertrophied)
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) NON E
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. G. Finnegan M. D.

1-20/21 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 22 1920

20 UNDERTAKER Wm J Tuckers Sons

ADDRESS North Ave

Ellen Collier

D50042 HEALTH DEPARTMENT—CITY OF BALTIMORE D50042

CERTIFICATE OF DEATH. 186

1-PLACE OF DEATH — REGISTERED No. C ...

CITY OF BALTIMORE (No. St. Joseph Hospital St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Collier

(Residence in Baltimore: No. 1765 E Monument St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, Aug 22 (Month) (Day), 1888 (Year)

7-AGE, 32 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo Proctor

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ida Bamberger

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Hamberger

(Address) Fullerton Md

15- FILED JAN 21 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Coroner and from inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Self reported (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park	7/22/21

20-UNDERTAKER W J Johns & Son North & Penna Ave

D50043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1209 Argyle Ave ST.) 17 (WARD) (adopted)

REGISTERED NO. C 1921-048

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Ruff

(Residence in Baltimore: No. 1209 Argyle Ave. St.; 2 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
~~Male~~	Col.	single

6-DATE OF BIRTH, April 7?, 1918.
(Month) (Day) (Year)

7-AGE, 7 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Malcolm Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emma Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Ruff

(Address) 1209 Argyle Ave

15- Filed JAN 21 1921 191 [illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(Duration) yrs. 6 mos. ds.

(Signed) J. N. Hemmeter M. D.
(Coroner.)

Jan. 19, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan 21, 1921
20-UNDERTAKER	ADDRESS
John J. O'Connor	538 Dolphin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec. 6-9-19—H. P. Co.—1000 Bks.

050044 HEALTH DEPARTMENT—CITY OF BALTIMORE 050044

91-084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S Gilmore ST.: 19th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phyllis M. Trott

(a) RESIDENCE. NO. 116 S Gilmore ST., 19th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 18th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanley B. Trott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Florence Styles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Stanley B Trott
(Address) 116 S Gilmore St

15 JAN 21 1921 19 [redacted] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1— 1921 to Jan 19 1921, that I last saw her alive on July 19th 1921, and that death occurred, on the date stated above, at 7. P. M m.

The CAUSE OF DEATH* was as follows:

Sub acute Bronchitis with Bronchial Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Teething Period

(duration) 6 yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physicians

(Signed) [illegible] M. D.

, 19 (Address) 1340 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	1-21st 1921
20 UNDERTAKER	ADDRESS 17 S. Calhoun St
Robert Brooks & Son	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050045

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050045

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N. Calvert St. 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola A. Whelan

(a) RESIDENCE. No. 1812 N. Calvert St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick G. Whelan

6 DATE OF BIRTH (month, day, and year) Jan 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	x	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Edward Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Mary C. Mackubin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant (Address) Wm. C. Whelan 1812 N. Calvert St.

15 FILED JAN 21 1921 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Jan 18, 1921, that I last saw h[illegible] alive on Jan 18, 1921, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2 hrs Uremia

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tests for reflexes & Motion & eyesight

(Signed) Wm. C. Whelan, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Jan 21 1921

20 UNDERTAKER ADDRESS

John Mitchell 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50046

CERTIFICATE OF DEATH.

120-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 N. Stricker ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Augusta Keene

(Residence in Baltimore: No. 906 N. Stricker St. St.; 72 yrs., 9 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, 5 April —, 1848
(Month) (Day) (Year)

7-AGE, 72 yrs. 9 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Nugent

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Caroline Lyons

13-BIRTHPLACE OF MOTHER (State or Country), Millville, N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Foster

(Address) 906 N. Stricker St.

15- JAN 21 1921 [illegible]
Filed....., 191.....
Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 18 1921, to Jany 20 1921, that I saw her alive on Jany 20 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease

(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) M. A. O'Neill M. D.

1/20/21, 192 0 (Address) 108 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, 1/24/191...

20-UNDERTAKER S. W. Offutt, Sr.

ADDRESS 225 S. Payson St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D50047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50047

X 28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 401 (St.) Hayward Av (Ward) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Charles McClure

(a) RESIDENCE. No. 401 Hayward Av St., Ward. Norfolk Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruby J McClure

6 DATE OF BIRTH (month, day, and year): Oct 8th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Floor Scraper

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Grinwood

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Albert McClure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Whittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Clarence Hastop

(Address) 401 Hayward Ave

15 [illegible] JAN 21 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Jan 19 1921

that I last saw him alive on Jan 19 1921

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gastro Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright Dodson, M. D.

1-9 1921 Address 3373 Baltic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Jan 21 1921
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50048

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 N. Henrietta ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Lekas

(a) RESIDENCE. No. 1 N. Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot 086

(b) General nature of industry, business, or establishment in which employed (or employer) Mariner

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Lekas

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Sarah A Gray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Irene Lekas
(Address) 1 N. Henrietta

15 FILED JAN 21 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Jan 18, 1921, that I last saw him alive on Jan 18, 1921, and that death occurred, on the date stated above, at 5 6. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1/20 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
BALTIMORE CEMETARY	JAN 21 1921

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-50049 14 D-50049 36 D-50049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Dorsey

(a) RESIDENCE. No. 718 Elliott ST. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? 1 yrs. 6 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lesley Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record
(Address) J. H. Hosp.

15 Filed JAN 21 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Jan 18, 1921, that I last saw her alive on Jan 18, 1921, and that death occurred, on the date stated above, at 4.35 p.m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X ray

(Signed) W. C. Davison, M. D.

19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 21 1921

20 UNDERTAKER ADDRESS

Clement & Hall 526 W. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50050

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 741 E. Preston ST.: 10 WARD)

2-FULL NAME John Henry Bickel

(a) RESIDENCE, No. 741 E Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Bickel

6 DATE OF BIRTH (month, day, and year) Apr 19 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supv. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Concrete Mfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Bickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Stefanski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina Bickel (Address) 741 E Preston

15 JAN 21 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1920, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 19, 1921, and that death occurred, on the date stated above, at 1-20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastro Oesophagus.

(duration) 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Upon —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Upon

(Signed) W. L. Gray, M. D.

Jan 20 1921 (Address) 6111 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan. 22 1921

20 UNDERTAKER H. W. Cook — ADDRESS 502 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50051 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 64 D 50051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 N Fulton Ave 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Moore

(a) RESIDENCE. No. 701 N Fulton Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard J. Moore

6 DATE OF BIRTH (month, day, and year): Nov 19 1866

7 AGE: Years 54 | Months 2 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James H Story

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Albaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs H Story
(Address) Queen Town Md

15 Filed JAN 21 1921 ROBERT A. KRAJTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Jany 19, 1921, that I last saw h.. alive on Jany 19, 1921, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Paralysis of Left Side

DDD

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Coma from 2nd attack

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

Jan 24, 1920 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge. DATE OF BURIAL: Jan 22 1921

20 UNDERTAKER: William Cook ADDRESS 1822 E. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal hemorrhage cerebral.

D50052

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D50052

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 714 Madison Ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Francis Herring

(Residence in Baltimore: No. 714 Madison Ave St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: February (Month) 25 (Day), 1849 (Year)

7-AGE: 71 yrs. 10 mos. 26 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): O'S V

9-BIRTHPLACE (State or country): Maryland.

PARENTS

10-NAME OF FATHER: Organd Herring

11-BIRTHPLACE OF FATHER (State or country): Maryland.

12-MAIDEN NAME OF MOTHER: Elizabeth Herring

13-BIRTHPLACE OF MOTHER (State or country): Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. W. Herring

(Address) 1st W Mosher St.

15- Filed JAN 21 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to, January 20 1921, that I saw him alive on January 20 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.
+ Bronchial asthma.
possibly

(Duration) 1 yrs — mos — ds.

Contributory (SECONDARY)
Arteriosclerosis

(Duration) — yrs — mos 7 ds.

(Signed), His Physician M. D.

January 24, 1921 [Address] 817 Hamilton Terr.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge

DATE OF BURIAL: January 22 nd, 1921

20-UNDERTAKER: W. W. Shriver

ADDRESS: 1018 Edmondson Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50053 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 Arch St.: 4 Ward) REGISTERED NO. 10-093

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Davis

(a) RESIDENCE. No. 235 Arch St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Davis (Address) 235 Arch

15 Filed JAN 21 1921 Robert A Lauter Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Jan 20 1921, that I last saw him alive on Jan 19 1921, and that death occurred, on the date stated above, at 1.40 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) La Grippe (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leavitt M. D.

Jan 21 1921 (Address) 1313 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 22 1921

20 UNDERTAKER Samuel T Hemsley ADDRESS 578 N Bond

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer." etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—8-24-14—M. & T.—2000 Bks.

D-50054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 W. Hoffman ST.; 17 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie E. McKelvon

(Residence in Baltimore: No. 541 W. Hoffman St.; 80 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 184[illegible] (Year)

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie McKelvon

(Address) 541 W. Hoffman

15-
Filed JAN 21 1921, 191
Wm. G. KRAUTER
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Jan (Day) 19, (Year) 1921

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 19 1921, that I saw her alive on Jan 18 1921, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 1 mos. 19 ds.

(Signed) C. H. Hardee M. D.

Jan. 20, 1921 (Address) 718 S. Stricker

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	1/21, 1921
20-UNDERTAKER Samuel T. Hemsley	ADDRESS 5787 W. Belvedere

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50055 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50055

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 218 S Ann ST.; Y WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Zechert

(a) RESIDENCE. No. 218 S Ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) august 16 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Zechert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Zubinsk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Andrew Zechert

(Address) 218 S Ann St

15 Filed JAN 21 1921 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 19th, 1921, to Jany 20th, 1921, that I last saw h~~im~~ alive on Jany 20th, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edw. M. Fitzgerald, M. D.

1/21/21, 19 (Address) 5 N. Washington ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 21 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank st

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50056 HEALTH DEPARTMENT—CITY OF BALTIMORE D50056

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 S Ann ST. 2 WARD)

2-FULL NAME Ida Kwiatkowska

(a) RESIDENCE. No. 418 S Ann ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Kwiatkowski
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland
12 MAIDEN NAME OF MOTHER Josephine Korzto
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Kwiatkowski
(Address) 418 S Ann St

15 Filed JAN 21 1921 16 [illegible] Burial Permit [illegible]
JAN 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 21, 1921, that I last saw h[illegible] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 3:25 A m.

The CAUSE OF DEATH* was as follows:

Senile Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

1-21, 1921 (Address) 508 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 22 1921

20 UNDERTAKER John N Weber ADDRESS 1803 Bank St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D50057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N Lexington ST.; 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas B McGee

(Residence in Baltimore: No. 1817 N Lexington St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 8th (Month) (Day), 1857 (Year)

7-AGE, 68 yrs. 1 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Capt 161
(b) General nature of Industry, business, or establishment in which employed (or employer): Police Dept

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, Bernard Mc Gee.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Ella Hayes.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Mc Gee.

(Address) 1817 N. Lexington St.

15-JAN 21 1921 Filed, 191.... ROBERT B ARAUTEN Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 19th (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1 1921, to Jany 19 1921, that I saw h[illegible] alive on Jany 19 1921, and that death occurred, on the date stated above, at 630P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Nephritis Interstitial

(Duration) Unknown yrs. mos. ds.

(Signed) W A O'Neill M. D.

Jany 20 1921 (Address) 108 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Jan 22, 1921

20-UNDERTAKER E and B Hasle

ADDRESS 115 E West St

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50058

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence L. Curtain.

(a) RESIDENCE. No. 911 N. Luzerne ST., ... WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Mr Curtain -

6 DATE OF BIRTH (month, day, and year) Oct 1 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80 Years	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Winchester Va -

PARENTS

10 NAME OF FATHER Wm B. Lavender

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Margaret Alston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md.

15 Filed JAN 21 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23rd 1919, to Jan 20th 1921, that I last saw her alive on Jan 19th 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis. (Paraplegia - Senile)

abt 18 mos.

(duration) 1 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia (Paralytica Senile)

Abt (duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

Jan 21st 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 22 1921
20 UNDERTAKER E J Hanning & Son 1935 E	ADDRESS Lafayette

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50059 HEALTH DEPARTMENT—CITY OF BALTIMORE D50059

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 379 S. Ellis ST.; 26 WARD)

2-FULL NAME Blanche Backert.

(a) RESIDENCE. No. 379 S. Ellis ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15-1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2/12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Backert.

11 BIRTHPLACE OF FATHER (city or town) Unknown.
(State or country) City

12 MAIDEN NAME OF MOTHER Mabel Sutter

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country) City.

14 Informant George Backert.
(Address) 379 S. Ellis St.

15 Filed JAN 21 1921 ROBERT I. KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 21, 1921, that I last saw her alive on Jan 20, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cyanosis Nonatorium

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Open Foramen Ovale

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. A. Geantz, M. D.

, 19 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan 21 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. If it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50060 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50060

CERTIFICATE OF DEATH.

4 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Clarke

(a) RESIDENCE. No. 672 Asburg st. ST.. WARD.

(Usual place of abode) about 5 yrs

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework D70

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Joe Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla Dyosin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. T. H.

15 Filed JAN 21 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1920, to Jan. 19, 1921.

that I last saw her alive on Jan. 19, 1921.

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enterocolitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Dr. L. J. Rigney, M. D.

1-20-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	Jan. 22 1921
20 UNDERTAKER	ADDRESS
M. Doyle	15 E. Lee or

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50061

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Frederick Ave ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erwin B. Ruppert

(a) RESIDENCE. NO. 2202 Frederick Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Erwin Ruppert

6 DATE OF BIRTH (month, day, and year) June 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Broker

(b) General nature of industry, business, or establishment in which employed (or employer) Self. 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER David Ruppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Down Town

12 MAIDEN NAME OF MOTHER Sarah Kann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Down Town

14 Informant Erwin B Ruppert

(Address) 5702 Park Heights Ave

15 Filed JAN 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Jan 20, 1921, that I last saw h.. alive on Jan 19, 1921, and that death occurred, on the date stated above, at 7-15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma - left side of neck

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual symptoms Chr

(Signed) Joseph Bonner, M. D.

, 19 (Address) 125 W Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan. 22 1921
20 UNDERTAKER	ADDRESS
H. M. Cook	502 E Pratt

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50062 ✓D.50062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 561 Mosher St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Friday.

(a) RESIDENCE. NO. 561 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alonzo Friday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica Long Island N.Y.

12 MAIDEN NAME OF MOTHER Ida Grover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Maryland

14 Informant Mary Gantt
(Address) 561 Mosher St.

15 Filed JAN 21 1921 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 19 21, to Jan 20, 19 21, that I last saw her alive on Jan 20, 19 21, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(32 Wks Foetus)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Victoria Lucy ... M. D.

1921 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt auburn cemetery	Jan 21 1921

20 UNDERTAKER John H Toddwin ADDRESS 142 N Hill St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYS... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Flynn

D.50063 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50063

CERTIFICATE OF DEATH. x 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital St.... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Edward Flynn

(a) RESIDENCE. No. Hartford Co Md. ST.... WARD Harford Co Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) July 5 - 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Geo. B. Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER E. Margaret Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Ella L. Smith

(Address) 1201 Edmondson Ave.

15 Filed ... 19... Robert P. Harrison, Registrar

JAN 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1921, to Jan 20 1921, that I last saw him alive on Jan 20 1921, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Edema lungs.

(duration) yrs. ... mos 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J W Mortondale, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 22 1921
20 UNDERTAKER	ADDRESS
H E Hughes	424 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50064

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.50064

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1834 West Lanvale ST. 16 WARD)

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sabina Peters

(Residence in Baltimore: No. 1834 W. Lanvale St.; 72 yrs. 3 mos. 20 ds.)

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: October (Month) 6 (Day), 1848 (Year)

7 AGE: 72 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): home

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Henry Albert

11 BIRTHPLACE OF FATHER (State or country): Baltimore City

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S. Parkhurst

(Address) 1410 Park Ave

15 JAN 21 1921

Robert P. Harrison, Burial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 20 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1918, to January 20th, 1921. that I saw her alive on January 20th, 1921, and that death occurred, on the date stated above, at 6.30 P m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. 2 mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alice S. Parkhurst M. D.

Jan 20, 1921. (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Jan 24 1921

20 UNDERTAKER: Joseph B. Cole

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50065

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50065

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Edmondson Ave. ST.: 16 WARD)

2-FULL NAME Virginia Webb Leithiser

(a) RESIDENCE. NO. 2026 Edmondson Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel L. Leithiser

6 DATE OF BIRTH (month, day, and year) February 2nd 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Bessie Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Edward Webb

(Address) 2026 Edmondson Ave.

Filed JAN 21 1921, 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st 1920, to Jan 19th 1920, that I last saw her alive on Jan 18th 1920, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Exp Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy DeCleary, M. D.

1/21, 1920 (Address) 400 N Poyson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge, Md	Jan 22nd 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Balto Street

mation should be carefully supplied. AGE should be stated EXACTLY. PH... NS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact sta... of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50066 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 120

CITY OF BALTIMORE: (No. 136 Rookwood Ave. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angeline Carr

(a) RESIDENCE. No. 136 Rookwood Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Plummer W. Carr

6 DATE OF BIRTH (month, day, and year) May 20" 1854

7 AGE Years	Months	Days	If LESS than 1 day. hrs. or mln.
66	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER Wilkerson Brashears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jane Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Emma Carr

(Address) 136 Rookwood Ave.

15 FILED , 19 Robert P. Harrison, Registrar

Burial Permit Issued

ANG 1 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20" 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1921, to Jan 20, 1921, that I last saw her alive on Jan 20, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Lewis Greenfield, M. D.

, 19 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 22" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50067 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50067

CERTIFICATE OF DEATH. X 119

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Prec No 3 Canton St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yoshio Nakamura Nakamura

(Residence in Baltimore: No. Prec No 3 Canton Eastbridge St.; yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Japanese

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1897 (Year)

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seaman
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country), Japan

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Palmer Statter

(Address) Bank St

15- Robert P. Harrison,
(Undertaker), ..., 191.....
Burial Permit Clerk. Registrar.

JAN 21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Jan 20 (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Sherry Lynd Russell M. D.
(Coroner)

Jan 21, 1921 (Address) 1600 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. Cremation

DATE OF BURIAL, Jan. 22 1921

20-UNDERTAKER Jos B. Cook

ADDRESS 1003 W. Balto St

8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.50068 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50068

CERTIFICATE OF DEATH.

172

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hosp. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A. Hagen

(Residence in Baltimore: No. 58 Hamilton Ave St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Aug. 19, 1886
(Month) (Day) (Year)

7-AGE, 34 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: sheet metal
(b) General nature of industry, business, or establishment in which employed (or employer): worker (shipyard)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Gustav C. Hagen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ida Vallis

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian G. Hagen

(Address) 3038 McElderry

15- Robert B. Harrison,
Filed JAN 21 1921, 191.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of base of skull
Fell striking iron ladder
at Balto. Dry Docks.
(Accident) (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)
Jan. 21, 1921 (Address) 1802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Balto. Dry Docks.

Former or usual residence 58 Hamilton Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Jan. 22, 1921
20-UNDERTAKER Mrs C. Miller	ADDRESS 2334 Jefferson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.50069

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50069

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 N. Bruth- ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Clark Wilkinson

(Residence in Baltimore: No. Above St.; 76 yrs. 2 mos. 12 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, ~~MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, May 8th 1844 (Month) (Day) (Year)

7-AGE, 76 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fire-Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Samuel Wilkinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susanna Clark

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas M. Wilkinson

(Address) 638 N. Bruth Ave

15- Robert P. Harrison,

Filed....., 191.....

JAN 21 1921 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1920, to Jan 20 1921, that I saw h[illegible] alive on Jan 20 1921, and that death occurred, on the date stated above, at 10P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) 2 yrs. ....mos. ....ds.

(Signed) L D Lehman M. D.

1/21, 1921 (Address) 211 N. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Jan 22, 1921

20-UNDERTAKER William H Gore — ADDRESS 1723 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bkr.

20.50070 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Columbia Ave St. 77 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Moore

(a) RESIDENCE. No. 519 Columbia ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice V Moore

6 DATE OF BIRTH (month, day, and year): 2/16/1877

7 AGE: Years 43 Months 4 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Washington

PARENTS

10 NAME OF FATHER: Edward F Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Kingstown R I

12 MAIDEN NAME OF MOTHER: Rachel Whitehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Miss M Boyer 1816 Dukeland Ave

15 Filed ... 19 ... Robert P. Harrison, Registrar

JAN 21 1921

(Burial Permit Clerk.)

(Fil 2 87)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 12 o'c. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Cor. Pyorrhea.

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) F W Blayney M.D.

(Address) 1302 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Jan 21 1921

20 UNDERTAKER: Wm Cook ADDRESS: 1302 E Balto

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Kanerabek)

20.50071

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50071

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) Little Sisters of the Poor, St. Lucas (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kanerabek.

(a) RESIDENCE. No. Fusten & Valley Sts. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✝ John Kanerabek

6 DATE OF BIRTH (month, day, and year) unknown ? 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	74?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Lesick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sister Florence, (Address) Fusten & Valley Sts.

15 Filed JAN 21 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 ..., to ..... 19 ..., that I last saw her alive on January 20, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

Jan 21 1921 (Address) 1133 Valley st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan 24 1921

20 UNDERTAKER: Frank Crook & Son — ADDRESS: 1906 Eastland

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

20.50072 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Light ST.; 24 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Myers

(Residence in Baltimore: No. 1729 Light St.; 2 yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Single

6-DATE OF BIRTH, Nov. 7 (Month) (Day), 1918 (Year)

7-AGE,	If LESS than 1 day,
2 yrs. 2 mos. 14 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Myers

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sarah Kirby

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kirby

(Address) 1729 Light St

15-

Filed JAN 21 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 20th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1921, to July 21 1921, that I saw her alive on July 20th 1921, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. [illegible] M. D.

Jan 21, 1921 (Address) 1340 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cem. DATE OF BURIAL, Jan. 22 1921

20-UNDERTAKER Margaret G. Flynn ADDRESS 1432 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50073 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50073

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Durham ST.: 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walburga Herold

(a) RESIDENCE. NO. 107 S Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Herold

6 DATE OF BIRTH (month, day, and year) Nov. 11 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Schramm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Schramm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Herold (Address) 107 S Durham

15 Filed JAN 21 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan 20, 1921, that I last saw h alive on Jan 20, 1921, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cardiac Renal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Chilton, M. D.

21, 1921 (Address) 1424 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	January 24 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	373 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine carefully as to correctness of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50074 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50074

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N Durham ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Amrein

(a) RESIDENCE. NO. 121 N Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Amrein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Eylear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Amrein

(Address) 121 N Durham

15 Robert P. Harrison, Registrar

JAN 21 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1918, to Jan. 19, 1921, that I last saw h im alive on Jan 18, 1921, and that death occurred, on the date stated above, at 1.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leo. Heller, M. D.

1. 20. 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	January 22 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 N

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50075 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50075

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.. 32 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Gross

(a) RESIDENCE. No. 612 Warner or ~~Wilkes~~ st. St.. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Linn (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M. C. H.

15 Filed JAN 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1920, to Jan. 20, 1921.

that I last saw him alive on Jan. 19, 1921.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) M. L. P. Rigney M. D.

1-20-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Jan 22 1921
20 UNDERTAKER	ADDRESS
S. L. Brown & Son	1511 Montego

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50076 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50076

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Albion Hotel

REGISTERED NO.

CITY OF BALTIMORE: (No. Richmond. Cathedral ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally G. Poe

(a) RESIDENCE. No. Richmond & Cathedral ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Jan 28 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentuckey

PARENTS

10 NAME OF FATHER Rubin Hingate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentuckey

12 MAIDEN NAME OF MOTHER Sarah Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentuckey

14 Informant Mr Edwin H. Poe (Address) Ruxton Md

15 Filed JAN 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921, to Jan 21, 1921, that I last saw h[er] alive on Jan 21, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Endocard itis. (Arteriosclerosis deformans 10 years)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Increasing Cardiac decomp ensation Dropsy (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At his home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Frank P. Kuhn, M. D.

, 19 (Address) 917 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 22 1921

20 UNDERTAKER Geary & Jenkins & Son Co ADDRESS Orchard & McCulloh Sts

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50077

CERTIFICATE OF DEATH.

92-154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Columbia Ave WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Baumback

(a) RESIDENCE. No. 1204 Columbia Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Baumback

6 DATE OF BIRTH (month, day, and year): April 13 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lizzie Vondenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: W. H. Sanders
(Address): 1204 Columbia Ave

15 Filed ....., 19.....

Registrar

JAN 22 1921

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to Jan 19, 1921, that I last saw h[illegible] alive on Jan 18, 1921, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Cancer Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Senility

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Hutchins, M. D.

1921 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 22 1921
20 UNDERTAKER	ADDRESS
Geo Lumbard & Son	647 W Balto

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact street address and NATURE of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50078 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50078

CERTIFICATE OF DEATH.

REGISTERED No. C 93

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 938 N. Gilmor St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Allenbaugh

(Residence in Baltimore: No. 938 N. Gilmor St.; 60 yrs., 9 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 11 (Day), 1860 (Year)

7-AGE, 60 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Keyser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Elizabeth Baker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Allenbaugh

(Address) 938 N. Gilmor St.

15- Robert P. Harrison, ..., 191.....

Burial Permit Clerk. Registrar.

JAN 22 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 15 1921, to Jan. 20 1921, that I saw h-e alive on Jan. 19 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

secondary

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pleurisy (Right)

(Duration) ... yrs. ... mos. 5 ds.

(Signed) G. Latoste Ewalt M. D.

Jan. 20, 1921. (Address) 905 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan. 24, 1921.

20-UNDERTAKER Chas. D. Black

ADDRESS 742 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Not tuberculous. No history of any chronic condition of heart.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50079

CERTIFICATE OF DEATH.

157

1-PLACE OF DEATH (CITY OF BALTIMORE: (No.) St Agnes' Hospital (St.) 27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hart

(a) RESIDENCE. No. 103 E. Virginia Ave. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9- 1921

7 AGE: Years | Months | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Notary
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: R. C. Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mr. R. C. Hart
(Address)

15 Filed Jan, 19 Robert P. Harrison Registrar

JAN 22 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1921, to Jan. 21, 1921, that I last saw him alive on Jan. 21, 1921, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorhage

(duration) Probably 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Winfield M. Craig, M. D.

, 19 (Address) St Agnes K.2011.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 22 1921
20 UNDERTAKER	ADDRESS
Robert Brookman	Baltimore Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

20.50080 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50080

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Arem (Baby)

(Residence in Baltimore: No. #312. W. 28th St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	—

6-DATE OF BIRTH, Oct 15 (Month) (Day), 1920 (Year)

7-AGE, — yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Gilbert Arem

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Pearl Snouffer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Arem

(Address) 312 W 28 St

15-

JAN 22 1921

Robert P. Harrison, 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 20 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to Jan 20 1921, that I saw h[illegible] alive on Jan 20 1921, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus Mort

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

Jan 20, 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Jan 22 1921

20-UNDERTAKER Chenoweth & Son — ADDRESS Chestnut St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Gastro Enteritis due to feeding.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D.50081 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50081

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1324 Whatcoat ST. 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion Isaac Butler

(Residence in Baltimore: No. 1324 Whatcoat St.; yrs., 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, ... Jan. 21, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Son

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Marion Butler

11-BIRTHPLACE OF FATHER (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER Charlotte Perry

13-BIRTHPLACE OF MOTHER (State or Country). Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Marion Butler

(Address) ..... 1324 Whatcoat

15- Robert P. Harrison,

Filed JAN 22 1921, 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-Enteritis

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. A. Kennedy M. D.
(Coroner.)

Jan. 21, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Jan. 23, 1921.
20-UNDERTAKER	**ADDRESS**
James A Dennis	1303 Pennsylvania

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50082 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50082

CERTIFICATE OF DEATH

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2 N. Conway St. ST. Joe Rhodes WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 2 N. Conway ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown (1881)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jim Honeywood (Address) 2 N. Conway St.

15 Filed Jan 22 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1924

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1924, to January 21, 1924, that I last saw him alive on January 20, 1924, and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy O.D.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. B. Smith, M. D.

, 19 (Address) 109 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	1/22 1924

20 UNDERTAKER Jno. Gelbach & Sons ADDRESS 406 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important. so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. could not determine whether apoplexy was due to Lues.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50083 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.50083

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. Edon ST.; 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche M Parratt

(a) RESIDENCE. No. 421 N. Edon ST., 5 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. J. Parratt

6 DATE OF BIRTH (month, day, and year) Jan 23, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant at

(b) General nature of industry, business, or establishment in which employed (or employer) Public Bath

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas J. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz A. Stephenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. S. Thompson

(Address) 519 Pennsylvania Ave.

15 Filed JAN 22 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to, Jan 20, 1921, that I last saw her alive on Jan 20, 1921, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

2 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green M. D.

1-20, 1921 (Address) 126½ Cresquick St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Jan 24 1921

20 UNDERTAKER ADDRESS

Josiah Lefler 1605 N North Ave

CAUTION.—Blanks must be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50084 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50084

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. University Hospital St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Henderson

(Residence in Baltimore: No. 701 N. Fulton ave St.; 87 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	widowed

6-DATE OF BIRTH, ..., 1834
(Month) (Day) (Year)

7-AGE, 87 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thos Allison

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Rebecca Allison

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address) .....

15-

Filed ....., 191...

JAN 22 1921

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Jan 22 1921, that I saw her alive on Jan 22 1921, and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Fractured femur (accidental)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis of long standing

(Duration) yrs. mos. 1 ds.

(Signed) Emma J. Howell M. D.

....., 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 33 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 701 N. Fulton Ave.

19-PLACE OF BURIAL OR REMOVAL, Bethel Cemetery Near Elkton, Cecil Co. Md. DATE OF BURIAL, Jan 24, 1921

20-UNDERTAKER Stewart & Bowen Company ADDRESS 108 N. Mott Ave.

William F. Worden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks accidental fracture of skull - slipped and fell (Hausstein) (W Horne)

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50085 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50085

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 612 S. Ann Street ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOZEFA NOWAK

(a) RESIDENCE. No. 612 S. Ann Street ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~White~~ M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Nowak,

6 DATE OF BIRTH (month, day, and year) Unknown 1842.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work,

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Poland~~ Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

11 Informant Rozalia Szczelecka, Daughter

(Address) 612 S. Ann St

[illegible] permit issued ..... 19 ..... Registrar

JAN 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany. 6th, 1921, to Jany. 21, 1921, that I last saw her alive on Jany. 20, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Aortic Insufficiency

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw M. Singewald, M. D.

1/21, 1921 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Mem.	Jany 24" 1921
20 UNDERTAKER M F Sadowski.	ADDRESS 705 S. Ann St.

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact address of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50086 D.50086

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Ellwood ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Radavichy

(a) RESIDENCE. NO. 506 N. Ellwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12 - 1892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
28	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Railroads in Ofice

(c) Name of employer Alabama & Baltimore

9 BIRTHPLACE (city or town) (State or country) Ned.

PARENTS

10 NAME OF FATHER Martin Radavich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Veronica Stankus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Radovich (Address) 506 N. Ellwood St.

15 Filed Robert J. Morrison, Registrar

AN 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to January 21, 1921, that I last saw him alive on Jan 20, 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 11 mos. 6 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 506 N Ellwood.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Thos. Fa Stevens, M. D.

1/21, 1921 (Address) 1866 Kenford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Jan. 24 1921
20 UNDERTAKER	ADDRESS
John Grebiancke	425 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50087 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50087

120

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Belvedere St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Bell Williams

(~~Residence in Baltimore~~: No. Luray Virginia St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... (Month) 1/21 (Day) 23d, (Year) 1870

7-AGE,	If LESS than 1 day,
50 yrs. 8 mos. 30 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas Dr Ford

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Sallie H. Bell

13-BIRTHPLACE OF MOTHER (State or Country), Accomack Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. Frank Dr Ford

(Address) Calvert & Lombard Sts

15-

Filed ..... 191.....

JAN 22 1921

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) January (Day) 22d, (Year) 1921

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1920, to Janu 22d 1921, that I saw h[illegible] alive on Janu 22d 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis associated with Cardiac Hypertrophy & Dilatation and Arterial Hypertension

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm M. Dabney M. D.

Janu 22d, 1921. (Address) Ruxton, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residance .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Greenmount Cem	Jan. 24, 1921
20-UNDERTAKER	ADDRESS
Henry W Jenkins & Son Co	Edward & Lombard Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 50088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50088

CERTIFICATE OF DEATH.

119

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4203 Connecticut Ave St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Klein

(Residence in Baltimore: No. 4203 Connecticut Ave St.; Life ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 21 (Day), 1867 (Year)

7-AGE, 53 yrs. 5 mos. 29 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Emil Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Josephine Miller

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo P Klein

(Address) 4203 Connecticut Ave

15-

Filed JAN 22 1921, 191.... Robert ... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 20 1921, that I saw her alive on Jan 20 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Stultz M. D.

Jan 20, 1921 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 22, 1921

20-UNDERTAKER J. Herring & Co — ADDRESS 1200 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

No other abnormal condition.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50089 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50089

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 902 Morris ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Walker

(Residence in Baltimore: No. 902 Morris St.: 8 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, not known ....., 1874
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
46 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Servant
(b) General nature of industry, business, or establishment in which employed (or employer): Private Home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Walker

(Address) 902 Morris St

15-

Filed ..... 191..... Robert F. Harrison, Registrar.

JAN 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Jan. 20 1921, that I saw her alive on Jan. 18 1921, and that death occurred, on the date stated above, at 7-30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of throat

Cut

(Duration) one yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Lee Scott M. D.

Jan 21, 1921 (Address) 906 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bulfinch Va DATE OF BURIAL, Jan. 22 1921

20-UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 50090 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1919 Division ST. 14 WARD) REGISTERED No. C 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Ford

(Residence in Baltimore: No. 1919 Division St.; yrs., 1 mos. 17 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colored	single

6-DATE OF BIRTH, Dec. (Month) 4 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
yrs. 1 mos. 17 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None old
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Ford.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Dorothy Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy Thompson

(Address) 1919 Division St.

15- JAN 22 1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 21, 1921 (Address) 2807 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Jan. 23, 1921
20-UNDERTAKER Daniel Easton	ADDRESS 916 Fremont

Matilda was doing nicely but developed a cough + had difficult breathing for past 3 or 4 days. D.N.K.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc.; *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50091 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50091

CERTIFICATE OF DEATH. 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 McCall ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Childs

(a) RESIDENCE. No. 137 McCall ST., 20 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles E Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eng

12 MAIDEN NAME OF MOTHER: Theresa Schlitzkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles E Childs
(Address): 137 McCall St

15 Filed JAN 22 1921, 19

Robert F. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 21, 1921, that I last saw him alive on Jan 21, 1921, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typhoid Bacteriological Exam

(Signed) Walter A Coe, M. D.

(Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 22 1921

20 UNDERTAKER: George Schmidt & Bro

ADDRESS: 1101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50092

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50092

CERTIFICATE OF DEATH.

151

H

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Light St. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Burkhardt

(a) RESIDENCE. No. 1712 Light St., 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 7 min.

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank J Burkhardt

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Goodrich

13 BIRTHPLACE OF MOTHER (city or town) Baltco
(State or country) Md.

14 Informant Frank J. Burkhardt
(Address) 1712 Light St.

15 Filed ... 19 Robert P. Harrison, Registrar

JAN 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 21, 1921, that I last saw h... alive on Jan 21, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) R E Hampson M. D.

Jan 21, 1921 (Address) 1604 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral.	June 24 19
20 UNDERTAKER	ADDRESS
Geo Fr Schwartz & Bro	2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50093 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50093

CERTIFICATE OF DEATH.

172 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3628 Elm Ave (St.) 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Flanwell

(a) RESIDENCE. No. 3628 Elm Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Flanwell

6 DATE OF BIRTH (month, day, and year): Jan 1 1839

7 AGE: Years 82 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob Flanwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Elizabeth Shiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Harry Flanwell
(Address) 3628 Elm Ave

15 Filed JAN 22 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Accidental fall while getting out of bed

Fracture of hip

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 6692 Roland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Jan 22, 1921

20 UNDERTAKER: Chenoweth Son — ADDRESS: Chestnut Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50094 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Linden Ave area Lake Drive 45

CITY OF BALTIMORE: (No. Eastern Ave Apt ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Frank Cohen

(a) RESIDENCE. No. Eutaw Place East ST., WARD.

(Usual place of abode) (If nonresident give city and State)

Length of residence in city or town where death occurred 48 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Cohen

6 DATE OF BIRTH (month, day, and year) July 24 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Solomon Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rachel Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant S. Frank (Address) Executor

15 Filed JAN 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from December 1, 1920, to Jan 21, 1921, that I last saw her alive on Jan 20, 1921, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma (of Colon) with metastases

(duration) 0 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 1920

Was there an autopsy? No

What test confirmed diagnosis? Pathological Specimen Growth

(Signed) Harry Cohen, M. D.

. 19 (Address) 1718 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cy	Jan 23rd 1921
20 UNDERTAKER	ADDRESS
David Goodman	1822 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50095 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50095

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 S. Ellwood ST. 1 WARD)

2-FULL NAME Matilda F. Guhl

(a) RESIDENCE. No. 1124 S. Ellwood av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Ralph Guhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Elz. Postler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Ralph Guhl

(Address) 1124 S. Ellwood av

15 Filed JAN 28 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 19 21, to Jan 21, 19 21, that I last saw her alive on Jan 21, 19 21, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

due to congenital weakness.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kaluzky M. D.

1/21, 19 21 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Carmel Cem.	1-22 19 21
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.50096 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50096

CERTIFICATE OF DEATH.

10-091

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 W. Hamilton av St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [redacted] Ellen Frances Wike

(Residence in Baltimore: No. 208 W. Hamilton av St.; ..... yrs., 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. 11, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 2 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John H. Wike

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Flora Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. H. Wike

(Address) 208 W. Hamilton av

15-

JAN 22 1921

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 21, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Jan 21 1921, that I saw her alive on Jan 21 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Convulsions

Toxaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Probably Grippal)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Smith M. D.

Jan 21, 1921. (Address) 4706 Harford av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Petersburg Pa

DATE OF BURIAL, 1-23, 1921

20-UNDERTAKER J J Moran

ADDRESS 300 E Baltimore

Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

10-50097

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-50097

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Mosher St.; 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Garner

(Residence in Baltimore: No. 403 Mosher St.; 10 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col	Married

6-DATE OF BIRTH, June (Month) 18 (Day), 1878 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jno. Garner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maria Travers

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Garner

(Address) 1403 Mosher

15- Filed JAN 23 1921, 191.. [illegible] KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1920, to Jany 18 1921, that I saw h[illegible] alive on Jany 17 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonar Tb Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Jany 21, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
[illegible] Cem Co	Jan 21, 1921
20-UNDERTAKER	ADDRESS
Sam'l H. Chase & Son	1400 Mosher

D. 50098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Ordinance Department.

CITY OF BALTIMORE (No. Curtis Bay. ST.: 4th WARD) REGISTERED No. C 186

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Carter.

(Residence in Baltimore: No. Anchor Hotel 610 E. Pratt St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
30 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer. U.S.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Seymour, Indiana.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Zulema ---------

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) MacLysle Gordon.

(Address) Curtis Bay Hotel.

15- Filed JAN 23 1921, 191... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 21st. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mangled about the face and body, due to explosion of hand grenade cabs.
Accidental Death.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jany. 21, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Newark N. J	Jan. 22 1921
20-UNDERTAKER JOHN F. DENNY	ADDRESS 716 LIGHT ST

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 50099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Ordinance Department

CITY OF BALTIMORE (No.) Curtis Bay. ST.: 15th WARD) 186

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edwin Kenly.

(Residence in Baltimore: No. 2208 Walbrook Ave. St.; yrs., 1 mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 6th. 1892, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
28 yrs. 6 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chemist.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry C. Kenly.

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md.

12-MAIDEN NAME OF MOTHER Mary M. Eschbach.

13-BIRTHPLACE OF MOTHER (State or Country), St. Marys, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth I. Kenly. (sister)

(Address) 2208 Walbrook Ave.

15-Filed JAN 23 1921 191 ROBERT E. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 21st. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mangled about the face and body, due to explosion of hand grenade cats.
Accidental Death.
(Duration) ...yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs.....mos.....ds.

(Signed) Otto M. Eberhardt M. D.
(Coroner)

Jany. 21 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Emporium Pennsylvania	Jan 24 1921

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

D-50100 D-50100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Ordinance Department

CITY OF BALTIMORE (No. Curtis Bay. ST.: 4 WARD) 186

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Burton.

(Residence in Baltimore: No. Anchor Hotel, 610 E. Pratt St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....30....yrs....mos....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 60
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Richmond, Va.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) MacLysle Gordon.

(Address) Curtis Bay Hotel.

15- Filed JAN 23 1921 ROBERT B. KRAUTER Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 21st. 1921. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mangled about the face and body, due to explosion of hand grenade cabs.
Accidental Death.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jany. 21, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Richmond Va	Jan 24, 1921

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-50101 HEALTH DEPARTMENT—CITY OF BALTIMORE D-50101

CERTIFICATE OF DEATH. 126

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Smithers

(a) RESIDENCE. NO. 1215-E. Oliver ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~Wife of~~ Alberta Smithers

6 DATE OF BIRTH (month, day, and year) 5/22/1854

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	61	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired do

(c) Name of employer Samuel Churchfield

9 BIRTHPLACE (city or town) (State or country) Middlesex Co Va

PARENTS

10 NAME OF FATHER Tyban Smithers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Catherine Waldon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King & Queen Co Va

14 Informant Nancy Smithers (Address) 1215 E Oliver St

15 Filed JAN 23 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1921, to Jan. 22, 1921, that I last saw h[illegible] alive on Jan. 22, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-18-21

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas M. D.

1-22 1921 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middlesex Co. Va. Whitehouse Va. DATE OF BURIAL 1/23/21

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50102 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50102

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) John Hopkins Hosp ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erich Duckert

(a) RESIDENCE. NO. 902 S Potomac ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	X	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Fred Duckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maggie Dinderski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed JAN 23 1921 ROBERT F. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 - , 1921, to Jan 22 - , 1921, that I last saw h... alive on Jan 22 - , 1921, and that death occurred, on the date stated above, at 5 12 a m.

The CAUSE OF DEATH* was as follows:

Retropharyngeal Abscess

(duration) — yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan 1, 1921

Was there an autopsy? no.

What test confirmed diagnosis? None

(Signed) W Davison, M. D.

1-21-21. 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cemetery	1/24/21
20 UNDERTAKER	ADDRESS
George J. Puttl	1735 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50103 HEALTH DEPARTMENT—CITY OF BALTIMORE D50103

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 525 Walnut St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Cauthorn

(Residence in Baltimore: No. 525 Walnut St. St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col.	married

6-DATE OF BIRTH, Jan. (Month) 2 (Day), 1877 (Year)

7-AGE, 44 yrs. mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Isaac Cauthorn

11-BIRTHPLACE OF FATHER (State or Country), Middlesex Co Va

12-MAIDEN NAME OF MOTHER Mary Croxton

13-BIRTHPLACE OF MOTHER (State or Country), Middlesex Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Creek

(Address) 310 Myrtle Ave.

15- ROBERT B KRAUTER

Filed JAN 23 1924 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said me (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. S. Hennessy M. D. (Coroner.)

Jan. 22 1924 (Address) 2802 Edmon[illegible] Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Somers's Mt. Meadow Va DATE OF BURIAL, Jan 23 1924

20-UNDERTAKER Samuel T Kemp ADDRESS 578 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050104

HEALTH DEPARTMENT—CITY OF BALTIMORE

050104

CERTIFICATE OF DEATH.

37

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Joseph Hospital (WARD) 17

2-FULL NAME Cora Summerville

(a) RESIDENCE. No. 720 Wilkins Alley WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Underwood

6 DATE OF BIRTH (month, day, and year) January 1883

7 AGE — Years: 38 — Months: — Days: — If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) Don't know

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Samuel Brown 720 Little George St

15 JAN 23 1921 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 19 21

I HEREBY CERTIFY, That I attended deceased from January 19 21 to Jan 20 19 21

that I last saw ... alive on Jan 21 19 21

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Abdominal dropsy

(duration) 2 wks

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. Whitewick, M. D.

1/23, 19 21 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn — DATE OF BURIAL: 1/23 1921

20 UNDERTAKER: Samuel T. Hawley — ADDRESS: 578 Riddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50105 HEALTH DEPARTMENT—CITY OF BALTIMORE D50105

CERTIFICATE OF DEATH.

28-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Brown

(a) RESIDENCE. No. 1631 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1905

7 AGE: Years 15 | Months 5 | Days 7 | If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Adam Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Clara Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant (Address) Clara Brown 1631 E. Monument

JAN 23 1921

ROBERT E. LEAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1921, to January 21, 1921, that I last saw her alive on January 21, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
& Tuberculosis

(duration) yrs. 3 mos. 5 ds.,

CONTRIBUTORY (Secondary) Pneumonia & Tuberculosis (duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. H. Kennard, M. D.

1-22, 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn | DATE OF BURIAL: Jan 25 1921

20 UNDERTAKER: Saml T. Hensley | ADDRESS: 578 N. Eden

TION is very important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

Baylis

050106

HEALTH DEPARTMENT—CITY OF BALTIMORE

050106

CERTIFICATE OF DEATH.

9c

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2336 Barclay St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Francis Baylis

(a) RESIDENCE. No. 2336 Barclay St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 01 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) May 21st 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Franklin Baylis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary J. Bickelhaupt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant J. W. Gen. F. Baylis (Address) 2336 Barclay St

15 Filed JAN 23 1921 ROBT. J. KRAUTER Registrar of Vital Statistics Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1921, to Jan. 22, 1921, that I last saw h.im alive on Jan. 22, 1921, and that death occurred .. .he date stated above, at 1. P m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal)

.....(duration) ....yrs. ....mos. ./.... ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Haer, M. D.

1-22, 1921 (Address) 5760 York Rd. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	Jan. 23rd 1921
20 UNDERTAKER Henry Hoen & Son	ADDRESS 1301 E Eager st

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1950107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

OK
167 Th. Sussex
1950107

REGISTERED No. 1950107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Fait Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Harned

(a) RESIDENCE. No. 2907 Fait Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William T. Harned

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Turner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant William T. Harned
(Address) 2907 Fait Ave

15 Filed JAN 23 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 21st, 1921, that I last saw him alive on Jan 20th, 1921, and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Scald. Accidently fell into a bucket of hot water

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Schaffer M. D.

, 19 (Address) 734 E Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stemmers Run Cem.	Jan. 23 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050108 HEALTH DEPARTMENT—CITY OF BALTIMORE 050108

CERTIFICATE OF DEATH.

164 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 W Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Lake

(Residence in Baltimore: No. 815 W Franklin St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... (Month) — (Day) — (Year) 1—

7-AGE,	If LESS than 1 day,
45 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nathan Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mollie Cordray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Lake

(Address) 815 W Franklin St

15-Filed JAN 23 1921, 191.. ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 20, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 10 1921, to January 20 1921, that I saw her alive on January 20 1921, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Contributing)

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Curtis M. D.

Jan 23 1921 (Address) 1750 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Jan 22 1921
20-UNDERTAKER, Samuel Hendley	ADDRESS 1708 Eutaw Pl

important. See instructions on back of certificate. ... properly classified. Exact statement of OCCUPATION is very

Remarks Stomach Poisoning due to eating sourkraut

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D50109 HEALTH DEPARTMENT—CITY OF BALTIMORE D50109

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St.: 17 WARD)
2-FULL NAME Rebecca Miller
(Residence in Baltimore: No. 525 W Franklin St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

20 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unkown, 1854
(Month) (Day) (Year)

7-AGE, 76 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Miller

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Sarah Goldman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jews

(Address)..... 1411 Eutaw St

15-
Filed JAN 23 1921 ROBERT J KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prostrated by Pneumonia

(Duration) Jan yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 22, 1921 (Address) 1003 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	Jan 23, 1921
20-UNDERTAKER Jack Lewis	ADDRESS 1411 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D50110 HEALTH DEPARTMENT—CITY OF BALTIMORE D50110

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.: 3 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Weinberg

(Residence in Baltimore: No. 23 S. Exeter St., St.: 1/2 yrs., mos. ds.)

Please write clearly in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: September (Month) 27 (Day), 1902 (Year)

7-AGE: 18 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: David Weinberg

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Ida Mermelstein

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman E. Tannenbaum

(Address) Womans Hospital

15- Filed JAN 23 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 20 1921, to January 21 1921, that I saw her alive on January 21 1921, and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(Duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Herman E. Tannenbaum M.D. M. D.

Jan 21, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 ds. In the State 18 yrs. 3 mos. 24 ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 23 S. Exeter St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, Jan. 23, 1921.

20-UNDERTAKER Jack Levin — ADDRESS 1411 E. Balt

D50111 HEALTH DEPARTMENT—CITY OF BALTIMORE D50111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2745 Maryland ave WARD) 17 79

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A Harris

(Residence in Baltimore: No. 2745 Maryland St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Femal	White	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1853 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Mc Cafferty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Warren

(Address) 2745 Maryland ave

15- JAN 23 1921 ROBERT E KRAUTER Registrar

Filed ..... 19.. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

Jan 22, 1921 (Address) 1532 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, Jan 24, 1921

20-UNDERTAKER David Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50112 50112 50112

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Jasper ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lovinia Chapman

(Residence in Baltimore: No. 222 Jasper St.; 2 yrs. 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Infant

6-DATE OF BIRTH, Nov 19, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas N Chapman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Teresa Colbert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas N Chapman

(Address) 222 Jasper St

15- Filed JAN 23 1921, 191.. ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1920, to Jan 22 1921, that I saw h.. alive on Jan 22 1921, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Ac Hepatitis
Entero Colitis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Defective Physical Development

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edw Short M. D.

Jan 22, 1921 (Address) 1512 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 24, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Ca ave

Important. See instructions on back of certificate. Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50113. HEALTH DEPARTMENT—CITY OF BALTIMORE D50113

CERTIFICATE OF DEATH. 126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital 15 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wicks.

(a) RESIDENCE. No. 1713 N. Fulton Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M. Wicks

6 DATE OF BIRTH (month, day, and year) Jan. 19-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant Balto. City Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Christopher Wicks

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Madeline Fuchs

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Harry W. Wicks
(Address) 1713 N. Fulton Ave

15 Filed JAN 23 1921 19 Registrar

ROBERT J. KRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from January 21, 1921, to Jan. 21, 1921, that I last saw him alive on January 21, 1921, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Bladder

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Enlarged Prostate

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? History and Physical examination.

(Signed) H. C. Marino, M. D.

1-21, 1921 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan. 25 1921
20 UNDERTAKER Harry W. Eblen	ADDRESS 1944 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Zumbrum.

D50114 HEALTH DEPARTMENT—CITY OF BALTIMORE D50114

CERTIFICATE OF DEATH.

150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2130 Oak St. ST.: 12 WARD)

2-FULL NAME Baby Zumbrum

(a) RESIDENCE. No. 2130 Oak st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 21, 1921

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Orrell S. Zumbrum

11 BIRTHPLACE OF FATHER (city or town) Manchester (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary K. Sprinkle

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Orrell S. Zumbrum
(Address) 2130 Oak St.

15 FILED JAN 23 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 22, 1921, that I last saw him alive on Jan 21, 1921, and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Defect.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Howard Bolton, M. D.

1/22. 1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester (Carroll Co.) Md. — DATE OF BURIAL: Jan. 23 1921

UNDERTAKER: Horace Burgee & Son — ADDRESS: 363 Stallo Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50115 HEALTH DEPARTMENT—CITY OF BALTIMORE D50115

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.; 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Hartman.

(a) RESIDENCE. No. Preston & Valley Sts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married Husband

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of of Frances Waymouth.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Bernard Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence.
(Address) Little Sisters of the Poor

15 JAN 23 1921 ROBERT E. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h alive on January 19, 1921,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardiac (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Osborne, M. D.

Jan., 19 (Address) 1138 Valley st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 24 1921
20 UNDERTAKER Lilly and Sons	ADDRESS 403 S. Mo Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50116 — 42 — D 050116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Kirby

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 FILED JAN 23 1921 ROBERT B. CHAUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1921 to January 21, 1921 that I last saw her alive on January 20, 1921 and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus (cervix)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test

(Signed) B. H. Erman M. D. 1/21/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan. 24 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. Dr. Wm Messick 1700 Linden ave

050117 HEALTH DEPARTMENT—CITY OF BALTIMORE 050117

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Leeds Ave. Hilgen ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Schaefer

(a) RESIDENCE. (Usual place of abode) No. Leeds Ave. near Helene ST., WARD.

Length of residence in city or town where death occurred 60 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Schafer

6 DATE OF BIRTH (month, day, and year): March 1st 1860

7 AGE: Years 60 | Months 10 | Days 10 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Baus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Baus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Schafer (Address) 2508 E Baltimore St

15 Filed JAN 23 1921 ROBERT E LEACH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1919, to Jan 20th, 1921, that I last saw her alive on Jan 18th, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Recurrent-Carcinoma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 2nd 1919

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Section

(Signed) William J. Messick M. D.

Jan 23 1921 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Jan 24th 1921

20 UNDERTAKER: J. B. Stephenson — ADDRESS: 2236 Frederick ave

IMPORTANT.—Answers to questions must be full and complete, and must be written in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50118

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 428 Wellington Lane ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Northam

(a) RESIDENCE. No. 428 Wellington Lane ST.: 7th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Northam

6 DATE OF BIRTH (month, day, and year) July 3 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm. J. Steffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Lillian Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Walter F. Northam

(Address) 428 Wellington Lane

15 Filed JAN 23 1921, 19 ROBT. I. CRAIGHTER Registrar Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Cecil, M. D.

19 (Address) 341 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 24 1921

20 UNDERTAKER H. B. Hupfeld ADDRESS 2336 Fred'k Ave

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

050019 HEALTH DEPARTMENT—CITY OF BALTIMORE 050119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 940 Gartsby St. 18 WARD) REGISTERED No. C 89

2-FULL NAME Howard E. Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 940 W. Gartsby St St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, Col | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 28, 1894
(Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), W. Va

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Celeza Thornton

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Phillips

(Address) 940 W Gartsby St

15- JAN 23 1921 ROBERT J KRAUTER
Filed ....., 191.... Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to June 12 1921, that I saw h[illegible] alive on June 12 1921, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH was as follows:*

Acute Bronchitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Coleman M. D.

Jan 22, 1921 (Address) 2138 McCulloh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery | DATE OF BURIAL, Jan 25, 1921

20-UNDERTAKER Leon Hall | ADDRESS 1741 D H Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks no other infections

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D50120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50120

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1647 N Mount ST.; 15 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos F. Savoy

(Residence in Baltimore: No. 1647 N Mount St St.; — yrs., 1 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Single

6-DATE OF BIRTH, January 22, 1921.
(Month) (Day) (Year)

7-AGE, — yrs. 1 mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9-BIRTHPLACE, (State or Country), 1647 N Mount St

PARENTS.

10-NAME OF FATHER, Earnest Savoy

11-BIRTHPLACE OF FATHER (State or Country), Charles Co Md

12-MAIDEN NAME OF MOTHER Mary Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Charles Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C L Summers

(Address) Babies & Childrens Clinic

15- Filed JAN 23 1921 191... ROBERT P. KRAUTER Registrar. Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 21 1921, to January 21 1921, that I saw him alive on January 21 1921, and that death occurred, on the date stated above, at 12.30 Pm. Jan 21 1921

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Bad Feeding

(Duration) ... yrs. 1 mos. ... ds.

(Signed) C L Summers M. D.

..., 191... (Address) Babies & Childrens Clinic

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, Jan 24th, 191...

20-UNDERTAKER Samuel Wright ADDRESS 1364 W Lexington

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50121

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N Broadway ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Maria Phelan

(a) RESIDENCE. No. 506 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: of Late D. Phelan.

6 DATE OF BIRTH (month, day, and year): 12/15/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: A. Corner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Mrs W. S. Green 506 N. Broadway

15 Filed JAN 23 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to Jan 20, 1921.

that I last saw her alive on Jan 20, 1921.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alfred Gage, M. D.

. 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 24 '21
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hayford Ave

CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on ba...

...on back of ... tificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

145637 / 50122

HEALTH DEPARTMENT—CITY OF BALTIMORE

50122 ×74

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master George H Mason jr.

(a) RESIDENCE. No. Mason Hotel Jacksonville, Florida WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jacksonville
(State or country) Florida.

PARENTS

10 NAME OF FATHER Geo H Mason

11 BIRTHPLACE OF FATHER (city or town) Jacksonville
(State or country) Florida

12 MAIDEN NAME OF MOTHER Georgia Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant J. Hopkins Hospital Records
(Address)

15 JAN 23 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 22, 1921, that I last saw h.. alive on Jan 22, 1921, and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Uremia following Operation for removal of tumor of Kidney

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Jacksonville Fla.

Did an operation precede death? Yes Date of Jan 22, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory Tests at Hopkins

(Signed) J. H. Thomason, M. D.

1-23, 19 (Address) Johns Hopkins Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jacksonville, Fla.	Jan 23 1921

20 UNDERTAKER J O Mitchell ADDRESS 1201 N Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050123

HEALTH DEPARTMENT—CITY OF BALTIMORE

050123

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Ensor

(a) RESIDENCE. No. Unknown ST., WARD. ...

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Unknown

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 JAN 23 1921 ROBERT P. LEUTER Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 19 21

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 15, to January 21, 1921, that I last saw her alive on January 20, 1921, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis
(No cerebral hemorrhage)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. B. Hartman, M. D.

1/21/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 24 1921
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern

TION is very important. See instructions on back of certificates.

D 50124 HEALTH DEPARTMENT—CITY OF BALTIMORE D/50124

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 421 W. Mulberry St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Kennedy-

(Residence in Baltimore: No. 421 W Mulberry St.; yrs., 85 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know (Month), 1 (Day), ... (Year)

7-AGE, 85 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nom 57
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bath City Md

PARENTS.

10-NAME OF FATHER, Darry

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos D Krueger

(Address) 421 W Mulberry St

15- Filed JAN 24 1921 [redacted] Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

..... (Duration) Dont Know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know Jaundice

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorman M. D. (Coroner.)

1-22, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan 23, 1921

20-UNDERTAKER H M Routson

ADDRESS 2238 N Mth

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

050125 HEALTH DEPARTMENT—CITY OF BALTIMORE 050125

CERTIFICATE OF DEATH. 1-175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Franklin Square Hospital ST.: 8 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank F. Ridgely

(Residence in Baltimore: No. 1734 North Lafayette St.; yrs., mos. 2 ds.)

Rogers Station

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Married

6-DATE OF BIRTH, unknown (Month) (Day), 1871 (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Howard County

PARENTS.

10-NAME OF FATHER, Edward Ridgely

11-BIRTHPLACE OF FATHER (State or Country) Howard County

12-MAIDEN NAME OF MOTHER Sarah Sutbiran

13-BIRTHPLACE OF MOTHER (State or Country) Howard County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva A. Ridgely

(Address) 1734 N. Pa. St.

15- ROBERT J. KRAUSER

FILED JAN 24 1921 101 Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture 7 & 8 ribs, both legs, internal injury, auto accident

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

Jan 26 1921 (Address) 706 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Franklin Sq Hosp In the of death yrs. mos. 1 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Park Lights & Belvidere Ave

Former or usual residence Rogers Station

19-PLACE OF BURIAL OR REMOVAL, St Marys Hamden

DATE OF BURIAL, 1-24, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Dr Fenton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50126

41

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 E. Eager ST.: 7 WARD)

2-FULL NAME Joseph A. Owens

(a) RESIDENCE. NO. 1520 E. Eager ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna G. Owens

6 DATE OF BIRTH (month, day, and year) Feb 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Smith - Penn

14 Informant Mary Sleysman

(Address) 1520 E. Eager St.

15 Filed JAN 24 1921 ROBERT T. LATTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1921

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to Jan. 23, 1921, that I last saw h.. alive on Jan. 22, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) + yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? not necessary

What test confirmed diagnosis? Examination of Dr. Reisinger

(Signed) Charles L. Clark, M. D.

Jan 23 1921 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
So Rest	Jan 25 1921
20 UNDERTAKER H. M. Cook	ADDRESS 602 E. Eager

TION is very important. See instructions on back of ... ck of certificates. ... g of property enclosed. Exact statement of OCCUPA...

Spec.—6-9-19—H. P. Co.—1000 Bks.

050127

HEALTH DEPARTMENT—CITY OF BALTIMORE

050127

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH S. Balto Gen. Hosp.

CITY OF BALTIMORE: (No. ..... ST.; 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie M. Kerns.

(a) RESIDENCE. No. 35 S. East Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George A Kerns

6 DATE OF BIRTH (month, day, and year) Aug 19. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baden Germany

12 MAIDEN NAME OF MOTHER Elizabeth Erdman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baden Germany

14 Informant Mr George A. Kerns

(Address) 35 S. East Ave

JAN 24 1921

ROBERT I. LEADER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1921, to Jan. 21, 1921, that I last saw h[illegible] alive on Jan. 21, 1921, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis.

(duration) √ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 18th

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) L. C. Dobihal, M. D.

19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1-24 1921
20 UNDERTAKER	ADDRESS
Williams Cook	502 E North

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50128 — 28 D 50128

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Rolfe

(a) RESIDENCE. No. 701 W. Lexington st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER William Rolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Lavinia Lance

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Hospital Records
(Address) U. T. H.

15 Filed JAN 24 1921 19 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1920, to Jan. 22, 1921, that I last saw him alive on Jan. 22, 1921, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. F. Rigney, M. D.

1-22, 1921 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/24 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave.

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D50129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50129

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Demby

(a) RESIDENCE. NO. 515 East St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Levan Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Miranda Shaden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 24 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 22, 1920. to January 20. 1921. that I last saw h en live on January 20, 1921. and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis ?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Myocardial insuffi ciency (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) R. Stevenson, M. D.

1/20/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

W. Auburn Poetry 1-25 1921

20 UNDERTAKER — ADDRESS

William Cook 502 E North

TION is very important. See instructions on back of c... be properly classified. Exact statement of OCCUPA... in plain terms, so that it may ... of certificates.

050130 HEALTH DEPARTMENT—CITY OF BALTIMORE 050130

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2607 Orleans St.: 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary S. Cullison

(Residence in Baltimore: No. 2607 Orleans St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, March 17, 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 9 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, James E. Ball

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Florence Truitt

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hilton R. Cullison

(Address) 2607 Orleans St.

15- JAN 24 1921 ROBERT I. LEAUTER
Filed....., 191... Registrar

Burial Permit Issued

Tuesday

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] (Coroner.) M.D.

1-22-21, 1921 (Address) 405 Dr.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, 1-25-21, 1921

20-UNDERTAKER William Cook — ADDRESS 502 E North

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50131 HEALTH DEPARTMENT—CITY OF BALTIMORE D50131

CERTIFICATE OF DEATH. 150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 S Bond ST.: 3 WARD)

2-FULL NAME Czeslaw Wolinski

(a) RESIDENCE. NO. 830 S Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Stanislaw Wolinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Stanislawa Krajewska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Stanislaw Wolinski
(Address) 830 S Bond St

15 Filed JAN 24 1921 ROBERT P. LAMPTEN Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 23, 1921, that I last saw h[illegible] alive on Jan 22, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Diphtheritic Endocarditis, VSV

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Russell, M. D.

Jan 23 1921 (Address) 830 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 24 1921

20 UNDERTAKER John A. Weber ADDRESS 1863 Bank

TION is very important. See instructions on back of ... may be properly classified. Exact statement ... OCCUPA- ... back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococci infection.
Congenital condition.
Cause unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50132 HEALTH DEPARTMENT—CITY OF BALTIMORE D-50132

CERTIFICATE OF DEATH.

REGISTERED NO. 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Lenox St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Susan Matthews

(a) RESIDENCE. No. 701 Lenox ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Benjamin Franklin Matthews

6 DATE OF BIRTH (month, day, and year) Sept 1845 estimated

7 AGE	75 Years	4 Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER John DeMoss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Tudor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Nettie F. Matthews
(Address) 701 Lenox St.

15 Jan 22, 1921

JAN 24 1921

ROBERT F. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1920, to Jan 22, 1921, that I last saw h[illegible] alive on Jan 22, 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows: OVER

Endocarditis + Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. B. Culbertson, M. D.

1/22/21 (Address) 1800 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. L. Balto Cemetery Company	1921
20 UNDERTAKER	ADDRESS
W. J. Lecknor Sons	Stockton Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No terminal hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50133

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Lemmon ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda McGraft

(a) RESIDENCE. No. 504 Lemmon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

11 Informant Chas. Carr

(Address) 580 Walnut St

15 Filed JAN 24 1921 ROBERT I. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921, to Jan 22, 1921, that I last saw h[illegible] alive on Jan 21, 1921, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease Valvular

(duration) 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) A.B. Stemmer

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? 504 Lemmon St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Thrombosis & Dyspnea

(Signed) O.N. Firor M. D.

1921 (Address) 712 S. Mary's Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 24 1921

20 UNDERTAKER John H. Toadvine ADDRESS 142 Orell St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

50134 HEALTH DEPARTMENT—CITY OF BALTIMORE 2/50134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 William St. 24 79 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip J. Thuman

(Residence in Baltimore: No. 1211 William St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 13, 1893 (Month) (Day) (Year)

7-AGE, 28 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Philip Thuman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Newman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Thuman

(Address) 1211 William St

15- Filed JAN 24 1921, 191... ROBERT F KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Jan 21 1921, that I saw him alive on Jan 21 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

from Cardiac (Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. F. Cushard M. D.

Jan 21, 1921 (Address) 3100 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). 1

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer — DATE OF BURIAL, 1-24-21

20-UNDERTAKER Edw B Hale — ADDRESS 1528 Mt St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 E West. ST.: 23 WARD)

REGISTERED NO. 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin J. Zang.

(a) RESIDENCE. No. 23 E West St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a ~~If married, widowed, or divorced.~~ HUSBAND of (or) ~~Widow of~~ Barbara. Zang.

6 DATE OF BIRTH (month, day, and year) Aug. 2 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer 63

(b) General nature of industry, business, or establishment in which employed (or employer) and Musician

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Zang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leona Schlander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Barbara. Zang.
(Address) 23 E West St

15 Filed JAN 24 1921 ROBERT P. BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1921

17

I HEREBY CERTIFY, That I attended deceased from 20 Jan., 1921, to 21 Jan, 1921, that I last saw h~~im~~e alive on 21 Jan, 1921, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Rabenstein, M. D.

Jan 22, 1921 (Address) 1412 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	1-25 1921
20 UNDERTAKER	ADDRESS
E and B Harle	115 E West St

That it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50136 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marshalls Court St. 15 WARD) Brooklyn Annex cab 64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. Mangunn.

(a) RESIDENCE. No. Marshalls Court St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Mangunn

6 DATE OF BIRTH (month, day, and year) June 7th 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) City Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas H. Mangunn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Charles Mangunn.
(Address) Brooklyn Md.

15 Filed JAN 24 1921 ROBERT B. REMSTER Registrar of Vital Statistics
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 19th, 1921, to Jan 22, 1921, that I last saw h[im] alive on Jan 21st, 1921, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Curtis Cove, Curtis Bay

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

1/22 1921 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill. Cem.	1-24 1921
20 UNDERTAKER	ADDRESS
E and B Harle	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 50137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 Madison Ave. (13 WARD)

2-FULL NAME Rachel Weis

(a) RESIDENCE. No. 2508 Madison Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 066

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rebecca Weis

(Address) 2508 Madison Ave

15 Filed JAN 24 1921 19.... ROBERT I. CLUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23 1921

17

I HEREBY CERTIFY, That I attended deceased from 6-1, 1920, to 1-23, 1921,

that I last saw her alive on 1-23, 1921,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

Character not determined

(duration) 1 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of Sept 1920

Was there an autopsy? No

What test confirmed diagnosis? Eye Ground Typhoid

(Signed) A. J. Barrett M. D.

, 19 (Address) 2000 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Hom'cidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	1/25 1921
20 UNDERTAKER J. Abrams Co	ADDRESS 1611 Madison

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 050138

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 4519 Park Heights Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Rettaliata.

(a) RESIDENCE. No. 4519 Park Heights, Ave; ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Rettaliata

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonia Rettaliata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant L Rettaalista.
(Address) ~~4519 Park Heights, Ave;~~

15 Filed JAN 24 1921 19 ROBERT I. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to January 22, 1921, that I last saw him alive on January 21, 1921, and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Hemiplegia and aphasia)

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Senile degeneration

Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Visible

(Signed) Milton P. Hull, M. D.

19 (Address) 1424 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	1/25 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50139 HEALTH DEPARTMENT—CITY OF BALTIMORE D50139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 N. Exeter ST.: 5 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wagner

(a) RESIDENCE. No. 9 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) June 15 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Raum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Denia Waters
(Address) 3201 O'Donnell St.

15 Filed JAN 24 1921 19 [illegible] Registrar
Burial Permit Oleed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1921, to Jan 22nd, 1921, that I last saw h[illegible] alive on Jan. 20th, 1921, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) [illegible] yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wessen, M. D.

1-22, 1921 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Jan. 24 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50140

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. Bellona Ave., Govans ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Victoria Snowden

(a) RESIDENCE. NO. 2117 St. Paul ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 81 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Henry Snowden

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Hughes Birkey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Marie Ann E. Curtis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Mary V. Sappington
(Address) 2117 St. Paul Street

15 Filed JAN 24 1921, 19 ... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 8th, 1921, to Jany 21st, 1921, that I last saw her alive on Jany 21st, 1921, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) Seven years yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) advanced age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No test

(Signed) John I Pennington, M. D.

, 19 (Address) 1826 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/24, 19 21
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50141

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1109 W. Hamburg ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Redmond

(a) RESIDENCE. NO. 1109 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 22 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Redmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co md

12 MAIDEN NAME OF MOTHER Genevie Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co md

14 Informant Harry Redmond
(Address) 1109 W. Hamburg st

15 Filed JAN 24 1921 ROBERT J. LAJER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Jan 22, 1921, that I last saw h— alive on Jan 20, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Crampton, M. D.

1/23, 1921 (Address) 507 Cath St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Jan 24 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	217 S. Pea

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1050142

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 1050142

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Belle Ge. ST. 15 WARD)

2-FULL NAME Elizabeth A. Brookes

(Residence in Baltimore: No. 4004 Belle Ge St.; 74 yrs. 1 mos. 10 ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: 12 (Month) 11 (Day), 1846 (Year)

7-AGE: 74 yrs. 1 mos. 10 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None 037
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Sarah Cavelin

13-BIRTHPLACE OF MOTHER (State or country): Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth A. Brookes

(Address) 4009 Belle Ge.

JAN 24 1921 ROBERT F. LEUTHE Burial Permit Clerk

Filed ..... 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 1 (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-8, 1921, to, 1-21 1921, that I saw h[illegible] alive on 1-21 1921, and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) — yrs — mos. 5 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos ..... ds.

(Signed), Henry Russell M. D.

1-23 1921 [Address] 3902 Groveland Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park | DATE OF BURIAL: Jany 24 1921

20-UNDERTAKER: John O'Rourke | ADDRESS: 1206 W. Fayette St

TION is very important. See instructions on back of certificate.

...ate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50143

39

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 N. Charles - ST.: 17 WARD)

2-FULL NAME Edmund Bryce Du Val

(a) RESIDENCE. No. 2209 N Charles ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes J Du Val

6 DATE OF BIRTH (month, day, and year) Feb 12 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Edmund B Du Val

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Lonsdale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Agnes J Du Val

(Address) 2209 N. Charles St.

15 Filed JAN 24 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1920, to Jan 22, 1921, that I last saw him alive on Jan 21, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Throat -
(Begining in palate)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Wm F Watson, M. D.

, 19 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jany 24 1921

20 UNDERTAKER John A Mitchell ADDRESS 1201 W Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Towson Ave/Brooklyn ST.: 25 WARD) 64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August H. Fischer

(a) RESIDENCE. NO. Towson Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia C Fischer

6 DATE OF BIRTH (month, day, and year) April 21 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia C Fischer (Address) Towson Ave Brooklyn Md

RUBY T. ELLIOTT

15 Filed JAN 24 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1921, to Jan 22, 1921, that I last saw h.. alive on Jan 21, 1921, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Jan 1921 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	JAN 25 1921 19
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L50145 HEALTH DEPARTMENT—CITY OF BALTIMORE L50145

CERTIFICATE OF DEATH. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Briscoe ST.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winnie L Jentner

(a) RESIDENCE. No. 1019 Briscoe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 5 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Jentner

6 DATE OF BIRTH (month, day, and year) Jan 22 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Jentner's 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H Abbott

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E Lloyd

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant George A Linde
(Address) 1019 Briscoe

15 Filed JAN 24 1921 ROBERT I. LEUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1921, to Jan 21, 1921, that I last saw h.. alive on Jan 21, 1921, and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

own

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Collapsed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1019 Briscoe St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? appearance

(Signed) Jno E Penn M. D.

1-22, 1921 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MOUNT OLIVET.	JAN 24 1921
20 UNDERTAKER JOHN F. DENNY 716	ADDRESS LIGHT ST.

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050146 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050146

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 E Lombard ST.: 2 WARD)

2-FULL NAME Eva A. Meinzinger

(a) RESIDENCE. No. 1839 E Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B Meinzinger

6 DATE OF BIRTH (month, day, and year) March 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Bankrutz Y Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Krbg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Meinzinger 1839 E Lombard

15 Filed JAN 24 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1917, to Jan. 21st, 1921, that I last saw h[er] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 5/15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac & Mitral Regurg
Chronic Interstitial Nephritis
Degeneration of the Cerebral

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia (Guaiac Stool Specimen)

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) A T Ries, M. D.

Jan 24 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	January 1921
20 UNDERTAKER	ADDRESS
Wendell Ryfel & Son	378 Penn

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50147 HEALTH DEPARTMENT—CITY OF BALTIMORE D50147

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 5006 Augusta Ave St.) (Hamilton WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R Kercheval Jr.

(a) RESIDENCE. NO. 5006 Augusta Ave ST. Hamilton WARD.
(Usual place of abode)

Length of residence in city or town where death occurred allo. his life yrs. mos. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single (Infant)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jany 18-1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer none

9 BIRTHPLACE (city or town) Hamilton
(State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles R Kercheval Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Marie Webster

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Charles R Kercheval Sr.
(Address) 5006 Augusta Ave Hamilton Md

15 Filed JAN 24 1921, 19 ROBERT J. GRAFTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 22 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jany 18, 19 21, to Jany 22, 19 21,
that I last saw h-im alive on Jany 22, 19 21,
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Congenital Atelectasis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green, M. D.

1/23 19 21 (Address) Hamilton Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Mem.	Jan 24 1921
20 UNDERTAKER Leo G. Cook	ADDRESS Forth & Harford

TION is very important. See instructions on back of ...ck of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D50148 HEALTH DEPARTMENT—CITY OF BALTIMORE D50148

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 291 S. Pulaski St. ST.) 20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Holzschuher

(Residence in Baltimore: No. 291 S. Pulaski St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	widow

6-DATE OF BIRTH, January 31, 1845 (Month) (Day) (Year)

7-AGE, 75 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gottfried Hempel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Herring

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Gartzke

(Address) 291 S. Pulaski St.

15- JAN 24 1921 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1921, to Jan. 23, 1921, that I saw her alive on Jan. 23, 1921, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

General paralysis.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility & Debility

(Duration) yrs. mos. ds.

(Signed) E. T. Dickey M. D.

Jan. 23, 1921. (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
G. Mathews	Jan. 26, 1921
20-UNDERTAKER George L. Schwab & Bro.	ADDRESS Pulaski & Ce

Spec. 6-9-19 H. P. Co. 1000 Blks.

Anna S. Magruder

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50149 — D50149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 50

CITY OF BALTIMORE: (NO. 305 S. Payson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna S. Magruder

(a) RESIDENCE. NO. 305 S. Payson ST. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed or divorced
HUSBAND of (or, ~~WIFE of~~) Fredk G. Magruder (deceased)

6 DATE OF BIRTH (month, day, and year) 1.23.1849.

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or X min.
	71	11	30	X

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work none — 100

(b) General nature of industry, business, or establishment in which employed (or employer) house wife.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mrs. J. F. Hayes
(Address) 305 S. Payson St

15 Filed ....., 19 [illegible] Registrar
JAN 24 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 22, 1921, that I last saw her alive on Jan. 21, 1921, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) X yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus and Exhaustion (duration) X yrs. 3 wks X ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) R. B. Hudson M. D.

1/22. 1921 (Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 25 1921
20 UNDERTAKER	ADDRESS
Geo. A. Schwa[illegible] & Bro	210 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050150 HEALTH DEPARTMENT—CITY OF BALTIMORE 050150

CERTIFICATE OF DEATH.

92-120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Kennedy ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Mortimore Ring

(a) RESIDENCE. NO. 2011 Kennedy ave ST., WARD. Aa Co Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Conductor Pa R R

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Pa R R

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W Ring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wesley W Ring
(Address) 122 Collins ave Balto Md

15 Filed ..., 19... ROBT. I. TRAUTER Registrar
JAN 24 1921 Record Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 21, 1921, that I last saw h in alive on Jan 21, 1921, and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ... yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) W. W. Brance, M. D.

1-21, 1921 (Address) 5 S Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 24 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W Baltimore Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

250151 HEALTH DEPARTMENT—CITY OF BALTIMORE 250151

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Casey

(a) RESIDENCE. No. 846 Halford ave. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Rzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital records.

(Address)

15 Filed JAN 24 1921 ROBERT B KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Jan. 23, 1921, that I last saw h.4 alive on Jan. 23, 1921, and that death occurred, on the date stated above, at 3-a m.

The CAUSE OF DEATH was as follows:

Diabetic Gangrene (both legs)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Eland C. Burton, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Jan. 26 1921

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050152 HEALTH DEPARTMENT—CITY OF BALTIMORE 050152

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument street / Eutaw Place ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Johanne Lethe

(Residence in Baltimore: No. Hebrew Aged Home St.; 4 yrs., 6 mos. —— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 2 (Day) 1838 (Year)

7-AGE, 82 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: assistant cook (b) General nature of industry, business, or establishment in which employed (or employer): Hebrew Asylum

9-BIRTHPLACE, (State or Country), Prussia (Germany)

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record of

(Address) Hebrew Hospital

15-

Filed JAN 24 1921 ROBERT E LEAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-30 1920, to 1-22 1921, that I saw her alive on 1-22 1921, and that death occurred, on the date stated above, at 2 55 P.M.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

cerebral apoplexy

(Duration) 3 yrs. 3 mos. XX ds.

CONTRIBUTORY (Secondary) cardiac dilatation, acute hypostatic pneumonia

(Duration) yrs. 11 mos. 5 ds.

(Signed) Benja Sachs M. D.

January 23, 1921. (Address) Hebrew Hospital Baltimore Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death —— yrs. —— mos. 23 ds. In the State not known ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence not known

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Har Sinai	1-23, 1921
20-UNDERTAKER David Sandheim	ADDRESS 118 W. Mt Royal

Spec.—6-9-19—H. P. Co.—1000 Bks.

145418
D50153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50153

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. John Hopkins Hospital ST.: 6 WARD)

2-FULL NAME Hallie Green

(a) RESIDENCE. NO. 345½ Fourth St. Balto ST. 2nd WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. unknown mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Green wife

6 DATE OF BIRTH (month, day, and year) March 1 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wake Co. North Carolina

PARENTS

10 NAME OF FATHER Joe Green

11 BIRTHPLACE OF FATHER (city or town) Wake Co (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Leach

13 BIRTHPLACE OF MOTHER (city or town) Wake Co (State or country) North Carolina

14 Informant (Address) J. H. Hospital Records

15 JAN 24 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1921, to Jan 21, 1921, that I last saw h.. alive on Jan 21, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pyloric stenosis of undetermined etiology. No evidence of malignancy for ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis - takes Luesalis Cardiac hypertrophy (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan. 8

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologically proved

(Signed) H. J. Pleth, M. D.

1.21, 1921 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Jan 24 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D50154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50154

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 McDonogh ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Middleton

(Residence in Baltimore: No. 1006 McDonogh St. 58 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Apl 22 (Month) (Day), 1862 (Year)

7-AGE, 76 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jos Eneley

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary J Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Prince.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), John A Middleton

(Address) 1006 McDonogh St

15- JAN 24 1921 ROBERT I. KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 22 1921, that I saw her alive on Jan 22 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Asthenia Dyspnoea
Chronic Interstitial Nephritis
1 Yr

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Left Hemiplegia

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Wm L Cattell M. D.

Jan 22, 1921 (Address) 603 W Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	January 25, 1921.
20-UNDERTAKER	ADDRESS
Robt J Turner	1422 N Broadway

important. See instructions on back of certificate.

050155 HEALTH DEPARTMENT—CITY OF BALTIMORE 050155

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1421 McCulloh ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loyal Dupree

(Residence in Baltimore: No. 1421 McCulloh St.; yrs., 1 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, December 25, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... infant

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James Dupree

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Irene Bell

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Dupree

(Address) 1421 McCulloh St

15- JAN 24 1921 ROBERT F. [illegible]
Filed....., 191.... Burial Permit No. 21664

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

Jan 23, 1921. (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	1/25/21

20-UNDERTAKER	ADDRESS
Frank W Cross Sr	1100 Monroe

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. In plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

Yaffie

050156 HEALTH DEPARTMENT—CITY OF BALTIMORE 050156

CERTIFICATE OF DEATH. 5-120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew aged Home ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Yoffie

(a) RESIDENCE. No. 111 Lisburn St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown OPP

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore St

15. Filed JAN 24 1921 ROBERT P. BRUCE Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Jan 23, 1921, that I last saw h[illegible] alive on Jan 23, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis 0720

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) M. J. Baylis M. D.

1/23, 1921 (Address) 210 Hospital St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	1/24 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

050157 HEALTH DEPARTMENT—CITY OF BALTIMORE 050157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 34 S. Eden Street ST.: 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Feldshon

(Residence in Baltimore: No. 34 S. Eden St 8 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1861 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. — mos. — ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

9-BIRTHPLACE, (State or Country) Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Baltimore St

15- ROBERT B KRAUTER

Filed JAN 24 1921 BURIAL Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Jan 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Geo. W. Preston M. D.
(Coroner.)

1/24, 1921 (Address) 1556 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	1/26, 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D50158 HEALTH DEPARTMENT—CITY OF BALTIMORE D50158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N Madeira St.; 6 WARD)

REGISTERED No. C 89

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Weaver

(Residence in Baltimore: No. 108 N Madeira St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug. 10, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Clarence Weaver

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Margaretta Richards

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Weaver

(Address) 108 N. Madeira St

15-

Filed JAN 24 1921 ... CRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Jan 22 1921, that I saw him alive on Jan 22 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. 3 ds.

(Signed) Adolph L. Eisenberg M. D.

Jan 24 1921 (Address) 220 S Bethel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mount Olivet Cemetery	Jan 24 1921
20-UNDERTAKER	ADDRESS
Miller Davis	413 N Eden St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50159 HEALTH DEPARTMENT—CITY OF BALTIMORE D50159

CERTIFICATE OF DEATH. X170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3302 Beach ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) York Pa.

2-FULL NAME William Billet

(a) RESIDENCE. No 3302 Beach ave ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lydia Billet

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamster for 3

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York, Pa
(State or country)

PARENTS

10 NAME OF FATHER Michael Billet

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant William H Billet
(Address) York Pa

15 Filed JAN 24 1921 BOYER & [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to Jan 23, 1921, that I last saw h in alive on Jan 23, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. Gilbert Darby, M. D.

, 19 (Address) 611 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Pa	Jan 24 1921
UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut st

TION is very important. See instructions on back of certificates.

Burial Permit Oleek

Spec.—6-9-19—H. P. Co.—1000 Bks.

050160 HEALTH DEPARTMENT—CITY OF BALTIMORE 050160

CERTIFICATE OF DEATH. X34

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. N. Broadway ST.: [illegible] WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcus Clifton Morgan

(a) RESIDENCE. No. Charleston W. Va ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A. Morgan

6 DATE OF BIRTH (month, day, and year) Sept 8th 1877

7 AGE	43 Years	4 Months	20 Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber co. W Va

(b) General nature of Industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston W Va

PARENTS

10 NAME OF FATHER Littleton Morgan

11 BIRTHPLACE OF FATHER (city or town) Charleston (State or country) W Virginia

12 MAIDEN NAME OF MOTHER Sophia Brake

13 BIRTHPLACE OF MOTHER (city or town) Charleston (State or country) W Virginia

14 Informant Rev J. H. Anderson
(Address) Buckhannon W Va

15 Filed JAN 24 1921 19 ROBERT B KRAUTH Registrar
Burial Permit 07508

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1920, to Jan 23rd, 1920, that I last saw him alive on Jan 23rd, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis - nephritis, Uraemia

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? No Date of

Was there an autopsy? Partial. (G. U. Tract)

What test confirmed diagnosis? Blood exam. & finding T. tubercle bacilli.

(Signed) H. Hartley, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buckhannon W Virginia	Jan 25th 1921
20 UNDERTAKER	ADDRESS
Geo J Smith	1000 W Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Henrietta M. Frontling

050161 HEALTH DEPARTMENT—CITY OF BALTIMORE 050161

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2544 Fred'k St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta M. Frontling

(a) RESIDENCE. NO. 2544 Fred'k St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Frontling

6 DATE OF BIRTH (month, day, and year) Jan 23 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(h) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frd Krumbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Frontling

(Address) 2544 Frederick St.

15 Filed JAN 24 1921 ROBT. J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 23, 1921, that I last saw h alive on Jan 23, 1921, and that death occurred, on the date stated above, at 10.00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus of Stomach

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Kelly M. D.

1921 (Address) 2227 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 25 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50162

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 W. Mulberry ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Johnson.

(a) RESIDENCE. No. 703 Mulberry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland,

PARENTS

10 NAME OF FATHER Dennis Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Parrish

(Address) 1628 Presstman St

15 JAN 24 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 19, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ....yrs. ....mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Abundance Sputum

(Signed) C. H. Hower, M. D.

, 1924 (Address) 712 S. Bond Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Bethel Cemetery	Jan 23 1921
20 UNDERTAKER	ADDRESS
Edw. Pennigold	1463 Carey

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1950163 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950163

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 Bolton ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Fithian Miller

(a) RESIDENCE. No. 2132 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced (or) WIFE of William C.Miller

6 DATE OF BIRTH (month, day, and year) Sept.16,1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Thomas K.Jaggard

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Matilda A.Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Miss Florence McFarland(niece

(Address) 2132 Bolton st.

15 Filed JAN 24 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1921, to Jan 23, 1921, that I last saw h[illegible] alive on Jan 22, 1921, and that death occurred, on the date stated above, at 10;20 A m.

The CAUSE OF DEATH* was as follows:

Senile Insufficiency

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E B Sutton, M. D.

Jan 23, 1921 (Address) 1911 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 25 1921
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50164

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50164

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Curley ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard North

(Residence in Baltimore: No. 138 N Curley St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, JAN (Month) 21 (Day), 1921 (Year)

7-AGE, X yrs. X mos. 2 ds.

If LESS than 1 day, 2 hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) ..... G.D.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert North

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Dorothy Strawbridge

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert North

(Address) 138 N. Curley St.

15- [illegible] E. FRAZIER

Filed ..... 191.... Burial Permit Given ..... 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, JAN (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JAN 21 1921 191, to JAN 22 191,

that I saw him alive on JAN 22 1921 191,

and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Ictus Neonatorum

followed by a General Convulsion

(Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. H. Decker M. D.

JAN 23., 191.. (Address) 928 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Jan 24..., 1921
20-UNDERTAKER	ADDRESS
Lilly & Zeller	403 S. Wolfe St

JAN 24 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Hollins St.; 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Temple

(a) RESIDENCE. NO. 2115 Hollins ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of John Temple

6 DATE OF BIRTH (month, day, and year) April 25. 1877

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: (own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): U.S.

12 MAIDEN NAME OF MOTHER: Rebecca Hoffman Paul Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.

14 Informant: John W Temple
(Address) 2115 Hollins St

15 JAN 24 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 22. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1920, to Jan. 22. 1921.
that I last saw h... alive on Jan 21. 1921.
and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Metastasis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-22-1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 25 1921
20 UNDERTAKER	ADDRESS
H W Routson	231 N Green

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050166

HEALTH DEPARTMENT—CITY OF BALTIMORE

050166

CERTIFICATE OF DEATH.

REGISTERED NO. 102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2668 Penna Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew R. Alexander

(a) RESIDENCE. No. 2668 Pennsylvania Ave WARD. 15

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 3rd May 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Alexander

11 BIRTHPLACE OF FATHER (city or town) Shirlet (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ebsie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) William B Alexander 2668 Penna Ave

JAN 24 1921

ROBERT E KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 23, 1921, that I last saw him alive on Jan 22, 1921, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

DVH

Gastro Enteritis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Chas J Wells, M. D.

19 (Address) Pk Sta 4th & Bala ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 24 1921

20 UNDERTAKER Josiah Sysor ADDRESS 1600 W North ave

TION IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50167

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

91-036 D50167

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Palmer

(Residence in Baltimore: No. St. Elizabeth's Home St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	

6-DATE OF BIRTH, Sent to home from Johns Hopkins Nov. 10/20 ....., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
about yrs. 14 mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 001
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), No particulars

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JAN 24 1921, 191... [illegible] Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1920, to January 22 1921, that I saw h[illegible] alive on January 22 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

..... Bronchio-Pneumonia

..... (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets

..... (Duration) yrs. mos. ds.

(Signed) Frank J Lloyd M. D.

Jan 23, 1921 (Address) 2005 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS

For "city burial"

JAN 24 1921

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 50168 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50168

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 921 McCulloh ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helleen Wardlow

(a) RESIDENCE. No. 921 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ″

(c) Name of employer ″

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frank Tenzle

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Helen Wardlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Helen Wardlow

(Address) 921 McCulloh St

JAN 24 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921. to Jan 21, 1921.

that I last saw h/ alive on Jan 20, 1921.

and that death occurred, on the date stated above, at 10 45 AM.

The CAUSE OF DEATH* was as follows:

Premature
(32 wks fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese M. D.

1-21, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health,

ADDRESS JAN 22 1921

ATTENDING PHYSICIAL

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2250169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2250169

91-082

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew E. Miller

(a) RESIDENCE. No. 243 W. Biddle St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4m/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanical 086

(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital.

15 Filed JAN 24 1921 19 ERNEST B. KRAUTER Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 19, 1921, to January 20, 1921, that I last saw him alive on January 19, 1921, and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis;
Cerebral thrombosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) B. A. Surman, M. D.

1/20/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER: Commissioner Health.	ADDRESS JAN 2[illegible]

Per. Wm. S. Nobbs

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50170 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50170

CERTIFICATE OF DEATH. #3

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Penna ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Bertha Cary

(a) RESIDENCE. NO. 716 Penna ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis B. Cary

6 DATE OF BIRTH (month, day, and year) Dec 13—1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Paris France

PARENTS

10 NAME OF FATHER Diselet

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Frances B. Cary

(Address) 716 Penna ave

15 Filed JAN 24 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from September 14 1919, to Jan 23rd 1921, that I last saw her alive on Jan 22d 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cancer of the Breast

(duration) 1 yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary) Starvation (duration) yrs. 1 mo. 15 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? yes Date of September 16 1919

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Frank W Lemmon, M. D.

Jan 24 1921 (Address) 322 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 26 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	708 Hanover St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50171 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50171

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Burke

(a) RESIDENCE. NO. Unknown 2807 Keyworth Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed 1/24 19 Robert [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1921

17 I HEREBY CERTIFY, That I attended deceased from December 13, 1920 to January 22, 1921 that I last saw him alive on January 22, 1921 and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? N. P. M.

What test confirmed diagnosis? Clinical test

(Signed) W. H. Corman M. D.

1/24/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem	1/25/ 1921
20 UNDERTAKER: John J. Keenan & Son	ADDRESS: 901 Hollins St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50172 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 79 REGISTERED NO.....

CITY OF BALTIMORE: (No. 1514 Division ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Bailey

(a) RESIDENCE. No. 1203 Cathedral ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all her life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) — 069

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael Farmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Union Memorial Hospital

15 Filed JAN 24 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1920, to Jan. 23, 1921, that I last saw h[illegible] alive on Jan 22, 1921, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Maryland.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Zimmerman, M. D.

Jan. 25 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL
West Liberty, Baltimore Co. Md. Jan 25 1921

20 UNDERTAKER ADDRESS
E. LeRoy Stiffler 1258 Nath. Ave

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50173 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50173

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 N. Caroline ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McGovern

(a) RESIDENCE. No. 1415 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McGovern

6 DATE OF BIRTH (month, day, and year) Aug 14 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Malicea Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Coyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss M. McGovern

(Address) 1415 N. Caroline St.

15 Filed Jan 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Jan 22, 1921, that I last saw her alive on Jan 23, 1921, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Daly, M. D.

19 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	1/25/20

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates. Enter stat... of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50174 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 Windsor Ave STR. 15 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Tiralla

(a) RESIDENCE NO. 3036 Windsor Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ernestine (Lucas)

6 DATE OF BIRTH (month, day, and year) June 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	"	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Purchasing Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Shipbuilding 080

(c) Name of employer Baltimore Dry Dock

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Francis Tiralla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia (Shannessy)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ernestine Tiralla
(Address) 3036 Windsor Ave

15 Filed Robert P. Harrison, Registrar
N24192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to Jan 22, 1921, that I last saw him alive on Jan 22, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Since Childhood (duration) yrs. mos. ds.

CONTRIBUTORY, (Secondary) (Nephritis), Ascites (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr A C Jonsson, M. D.

, 19 (Address) 1303 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 192[illegible]
20 UNDERTAKER	ADDRESS
Hasson Sons	1827 N Mitchell

TION is very important. See instructions on back of certificates.

D.50175 Swakowski D.50175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Swakowski

(Residence in Baltimore: No. 244 S Ann St. 27 yrs., 7 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, June (Month) 8th (Day), 1894 (Year)

7-AGE, 27 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 140
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Day laborer

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Swakowski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Jozefa Larkowski,

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Swakowski,

(Address) 244 S. Ann St

15- Robert P. Harrison,

Filed....., 191.... Registrar.

Burial Permit Clerk.

JAN 24 192

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Acid

Coma and Edema (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner)

1-25, 192.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Jany 25th, 1921.
20-UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50176 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50176

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 238 S Wash't ST.; 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stefchen

(a) RESIDENCE. No. 238 S Wash't ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24. 21

7 AGE Years Months Days If LESS than 1 day, 1 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Bolington
(State or country) England

PARENTS

10 NAME OF FATHER John Stefchen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Wosowicz

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary Wosowicz
(Address)

15 Filed 19

Registrar

Robert P. Harrison,
Burial Permit Clerk.

JAN 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 —, 19 21, to Jan 24, 19 21, that I last saw h[illegible] alive on Jan 24, 19 21, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Sysonett M. D.

1/24/21 19 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Jany 26th 1921.

20 UNDERTAKER M. J. Sadowski. ADDRESS 905 S. Ann

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks. Maria Siglinska.

D.50177 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50177

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 S Decker ave ST.; 1 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Siglinski

(Residence in Baltimore: No. 801 S Decker ave St.; 9 yrs., 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov 17, 1911 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
9 yrs. 2 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): Girl

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Siglinski.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Stanislava Roszyk.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Siglinski.

(Address) 801 S. Decker ave.

15- Robert P. Harrison, ..., 191.....

Burial Permit Clerk Registrar.

AN 24 1921

Important: See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to June 22 1921, that I saw h e alive on June 22 1921, and that death occurred, on the date stated above, at 12 15 P m.

The CAUSE OF DEATH* was as follows:

Mitrale Insufficiency

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) ....yrs. 6 mos. 4 ds.

(Signed) Henry Gruen M. D.

6/27/21, 191... (Address) 1508 Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	June 24, 1921

20-UNDERTAKER	ADDRESS
M F. Sadowski.	705 S. Ann St

Spec.—8-24-14—M. & T.—2000 Blks.

050178 HEALTH DEPARTMENT—CITY OF BALTIMORE 050178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Tyson ST.; 11 WARD) REGISTERED No. C 1920

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolie Hall

(Residence in Baltimore: No. 824 Tyson St.; 59 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Colored	Widow

6-DATE OF BIRTH, Oct 15 1861 (Month) (Day) (Year)

7-AGE, 59 yrs. 2 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Cambridge Md

PARENTS.

10-NAME OF FATHER, Murray Robson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Delia Robson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dolie Hall

(Address) 824 Tyson

15- Filed JAN 25 1921, 191.. ROBT. J. KRAUTER REGISTRAR. BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 22, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7th 1919, to Jan 22 1921, that I saw h er alive on Jan 18 1921, and that death occurred, on the date stated above, at 11:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Large Diabroid many years

(Duration) yrs. mos. ds.

(Signed) Chas. J. Keller M. D.

Jan 24, 1921 (Address) 1700 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Elm	Jan 25 1921
20-UNDERTAKER Sam F. Chaney Son	ADDRESS 1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

250179 — 28 — 250179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Glum (Glenn)

(a) RESIDENCE. No. 39 E. Lee st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Mississipp i

PARENTS

10 NAME OF FATHER Albert Glum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mississippi

12 MAIDEN NAME OF MOTHER Mary Mosely

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mississippi

14 Informant: Hospital Records
(Address): M. T. H.

15 FILED JAN 25 1921 ROBERT E. LEACHER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1921, to January 22, 1921, that I last saw h... alive on Jan. 21, 1921, and that death occurred, on the date stated above, at 12.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? T. B. in sputum

(Signed) H. F. Augey, M. D.

1-22-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 25 1921

20 UNDERTAKER: John H. Trading — ADDRESS: 142 Mulberry

HOW is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50180

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1751 Mulligan ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Sparks

(a) RESIDENCE. No. 1751 Mulligan ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Preston. Md
(State or country)

PARENTS

10 NAME OF FATHER Ruben Sparks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Edna Drake

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ruben Sparks
(Address) 1751 Mulligan St

15 Filed , 19 [illegible]
JAN 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 20th, 19 21, to Jan 24th 19 21,
that I last saw her alive on " 23rd, 19 1,
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Levinson, M. D.

1-24, 1921 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Jan 25 1921
20 UNDERTAKER John H. Fradkin	ADDRESS 142 Ostend St

Please write very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50181

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2434 Jefferson ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward T. Hutson

(a) RESIDENCE. No. 2434 Jefferson ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. -mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lida J. Hutson

6 DATE OF BIRTH (month, day, and year) June 8—1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Railway Express

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward E. Hutson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Haddaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lida J. Hutson (Address) 2434 Jefferson St

15 Filed JAN 25 1921 19 [illegible] Registrar

Burial or Removal Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to Jan. 23, 1921, that I last saw him alive on Jan 22, 1921, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) A. T. Reis, M. D.

Jan 24, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 26 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Pratt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50182 D 50182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Virginia Weisbrod

(a) RESIDENCE. NO. John Hopkins Hosp. ST., WARD. Lutherville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? 9 yrs. 5 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 22nd 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	5.	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Walter Weisbrod

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ida Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records Baltimore Md

15 Filed JAN 25 1921 ERNEST I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 24, 1921, that I last saw h.. Em.. alive on Jan 24, 1921, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) ... yrs. ... mos. 4 ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W Brian, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery-Towson	Jan 25 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

FOR IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50183 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Clifton Ave St.: 15 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Edward Hyde Robbins

(a) RESIDENCE. No. 3101 Clifton Av St. 15 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 16 ds. How long in U. S., If of foreign birth? 72 yrs 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L. Robbins

6 DATE OF BIRTH (month, day, and year) Feby-7-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman 18

(b) General nature of industry, business, or establishment in which employed (or employer) Presbyterian Church

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Horace H. Robbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known Conn.

12 MAIDEN NAME OF MOTHER Mary Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known Conn.

14 Informant Mrs S. A. Dodds (daughter) (Address) 3101 Clifton Ave

15 Filed JAN 25 1921 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from ..., 1910, to Jan. 23rd, 1921, that I last saw him alive on Jan. 20th, 1921, and that death occurred, on the date stated above, at 11.00 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Acute Cardiac Failure

Suddenly, 10 min.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination of heart

(Signed) S. A. Dodds, M. D.

, 19 (Address) 3101 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Jan-25/1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOBBEN, Successor)

ADDRESS 108 W. NORTH AVE.

This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50184

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bredler & Sellman Hosp ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hampson Hubert Biedler M.D.

(a) RESIDENCE. No. 724 N. Charles ST., 12 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. 4 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Annie Biedler

6 DATE OF BIRTH (month, day, and year) Aug. 26. 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Surgeon

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) near Leroy Va

PARENTS

10 NAME OF FATHER Milton Biedler

11 BIRTHPLACE OF FATHER (city or town) New Market Va (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Keyser

13 BIRTHPLACE OF MOTHER (city or town) Washington Co (State or country) Virginia

14 Informant W T Biedler (Address) 2802 W. Calvert St

15 Filed JAN 25 1921 Registrar

ROBT. J. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17

I HEREBY CERTIFY, That I attended deceased from January 17, 1921, to Jan 23, 1921, that I last saw him alive on Jan 23, 1921, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 5 yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1197 W. Saratoga St Baltimore Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. H. Bo. Sellman, M. D.

, 19 (Address) 5 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 26 1921.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

THIS IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50185

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D50185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S. Ellwood ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Stenger

(a) RESIDENCE. NO. 18 S. Ellwood ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Stenger

6 DATE OF BIRTH (month, day, and year): July 20 1845

7 AGE — Years: 75 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: John B. Bousselett

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Charlotte Brecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): J. A. Moran 3000 E. Baltimore St.

15 Filed JAN 25 1921 19 ROBERT E. CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 19 21, to Jan 24, 19 21,

that I last saw h... alive on Jan 21, 19 21,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr. M. D.

19 21 (Address) 26 28 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int. Carmel Cem.

DATE OF BURIAL: 1-26- 19 21

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E. Baltimore St.

HOW IS VERY important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Houska

D 50186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 50186

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 N. Castle ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Houska

(Residence in Baltimore: No. 134 N Castle St St.; ....yrs,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1 (Year)

7-AGE, 17 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, John Houska

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Emma Ramusha

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Houska

(Address) 134 N Castle St

15-

Filed JAN 25 1921, 191.... ROBERT P. KRAUTH Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 23 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Jan 23 1920, that I saw h[illegible] alive on Jan 17 1921, and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis, Mitral Insufficiency

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

..... (Duration).....yrs.....mos.....ds.

(Signed) F F Ramuska M. D.

....1....., 1921 (Address) 800 N Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	Jan 26, 1921
20-UNDERTAKER Frank Loverbier	ADDRESS 1016 Eastlavd

Spec.—6-9-19 H. P. Co.—1000 Bks.

145 761
D50187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 D50187

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waldo Schultz.

(a) RESIDENCE. No. 1942 Harford Ave. ST., Balto md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wade Schultz

11 BIRTHPLACE OF FATHER (city or town) Indiana
(State or country)

12 MAIDEN NAME OF MOTHER Irene Teagues

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Johns Hopkins Hospital Nurse
(Address)

15 Filed JAN 25 1921 ROBERT E. LEAVELL Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 23, 1921, that I last saw h.. alive on Jan 23, 1921, and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis meningitis

(duration) ....yrs. .... mos. 14 ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) W. Davison, M. D.

1-23, 1921 (Address) H H Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Jan 25 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

From 12 to 24 hours after death. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50188

64-09

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3904 Rhoda Road ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine McCormick

(a) RESIDENCE. NO. 3904 Rhoda Ave ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McCormick

6 DATE OF BIRTH (month, day, and year) Sept 8-68

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) House-work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Barbara Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Catharine McCormick

(Address) 3904 Rhoda Ave

15 Filed . 19 ... Registrar

JAN 25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 23, 1921,

that I last saw h[illegible] alive on Jan 22, 1921,

and that death occurred, on the date stated above, at 3 1 m.

The CAUSE OF DEATH* was as follows:

exhaustion

Cerebral Hemorrhage

(duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary

(duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same

(Signed) Jas L. Thomas, M. D.

Jan 25 1921 (Address) 2480 30d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 26 1921

20 UNDERTAKER	ADDRESS
Philip Henry	2016 Orleans

TION is very important. See instructions on back of certificates.

4/23 Spec.—6-9-19—H. P. Co.—1000 Bks.

D50189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50189

CERTIFICATE OF DEATH.

104-02

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1922 E. Eager ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Berger

(a) RESIDENCE. No. 1922 E. Eager ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER Carmelo Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt md

12 MAIDEN NAME OF MOTHER Lottie Leach.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Carmen Berger
(Address) 1922 E. Eager

15 Filed ..... 19 ..... Registrar

JAN 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1921, to Jan. 23, 1921, that I last saw h[illegible] alive on Jan. 23 1921, and that death occurred, on the date stated above, at 1 45 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Obs Examination

(Signed) C F Knaggenhein, M. D.

1-24 1921 (Address) 3201 Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jany 25 1921

20 UNDERTAKER Robt J Turner Inc ADDRESS 1414 W. Baltimore

TION is very important. See instructions on back of certificates.

D 50190

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 50190

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lucy's Lane near B.R.R. 150 St. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Remly (Joseph Howard Remly)

(Residence in Baltimore: No. E Side Lucy's Lane St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M

4-COLOR OR RACE W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Infant

6-DATE OF BIRTH January 23, 1921 (Month) (Day) (Year)

7-AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 15 min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER Harry Remly

11-BIRTHPLACE OF FATHER (State or country) Balt

12-MAIDEN NAME OF MOTHER Rachael Horton

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Horton

(Address) Lucy's lane

15. ROBERT J. KRAUTER

JAN 25 1921 (Date Received) CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH January 23, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to ....., 191..., that I saw him alive on Jan 23, 1921, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Dyspnoea

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Clark M. D.

Jan 24, 191... (Address) 1201 N. Chapel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Green Mount

DATE OF BURIAL January 25, 1921

20 UNDERTAKER Wendell Duffy & Son

ADDRESS 37 S Mo

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

= Nadolny =

D 50191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50191

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 227 S. Washington St. (ST.; W WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Nadolny

(Residence in Baltimore: No. 227 S. Washington St. St.; 2 yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Single

6-DATE OF BIRTH, Nov. (Month) 30 (Day), 1919 (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 1 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant. do
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Stanislaus Nadolny.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Victoria Wiatrowska.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victoria Nadolny.

(Address) 227 S. Washington St.

15- ROBERT B KRAUTER

Filed JAN 25 1921 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23 1921, to Jan 24, 1921, that I saw h[illegible] alive on Jan 23 1921, and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Convulsions

(Duration) ....yrs. 12 mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Keller M.D. M. D.

1-24-21, 1924. (Address) 193 S. Wright St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL. Jany 25, 1921.

20-UNDERTAKER W. F. Sudowski. ADDRESS 705 S. Ann St.

D50192 HEALTH DEPARTMENT—CITY OF BALTIMORE D50192

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1340 Eastman St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Powell

(Residence in Baltimore: No. 1340 Eastman St. 9 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, March 5, 1914
(Month) (Day) (Year)

7-AGE, 6 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. F. Powell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Flenus Richardson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. F. Powell

(Address) 1340 Eastman St.

15- JAN 25 1921 Filed....., 191... [redacted] Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardia Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. 2 wks. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 24, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Jan 25, 1921
20-UNDERTAKER James H. Dennis	ADDRESS 1303 FREEMAN ST.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-09 D 50193

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Sydenham Hospital ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Hall.

(a) RESIDENCE. No. 1307 Hillman ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan. 22-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	—	2	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md

PARENTS

10 NAME OF FATHER Wm. C. Hall

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Kirkpatrick

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Wm C Hall
(Address) 1307 Hillman St.

15 Filed JAN 25 1921 ROBERT I. KRAUTH Registrar
Burial Permit Oiad

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 23, 1921, that I last saw h.. alive on Jan 23, 1921, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B Magruder M. D.

1/24/1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 26 1921
20 UNDERTAKER	ADDRESS
Edmund H. Canfield	1912 E Eager St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50194 HEALTH DEPARTMENT—CITY OF BALTIMORE

D/50194 152 9990

CERTIFICATE OF DE[redacted] NO. 43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 W. Mulberry St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Johnson

(a) RESIDENCE. No. 704 W. Mulberry St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore, Maryland.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Phoebe Johnson

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Mother (Phoebe Johnson).
(Address) 704 W. Mulberry St.

15 [illegible] 19 [illegible] Registrar

JAN 25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1921

17 I HEREBY CERTIFY, That I attended deceased from January 22nd 1921, to January 22nd 1921, that I last saw h. im alive on January 22nd 1921, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Accidental hemorrhage from Cord.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) ?

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? none

(Signed) J. Harris Reese, M. D.

, 19 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

JAN 25 1921

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

b50195 HEALTH DEPARTMENT—CITY OF BALTIMORE b50195

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 2010 Penna Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruthie Green

(a) RESIDENCE. No. 2010 Penna Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow.

6 DATE OF BIRTH (month, day, and year) July 9-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress. Ott

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Laura Green (Address) 2010 Pennsylvania Ave

15 Filed JAN 25 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Jan 23, 1921, that I last saw her alive on Jan 22, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Central Harmorhage (duration) — yrs. — mos. one ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?.. no.

What test confirmed diagnosis? Regular

(Signed) J. C. Linck M. D.

(Address) Jan 24-21 1318 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 23 1921

20 UNDERTAKER Edw. Ringgold ADDRESS 1463 Carey

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50196 HEALTH DEPARTMENT—CITY OF BALTIMORE D50196

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 West Mulberry ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hoos

(a) RESIDENCE. No. 1203 West Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hoos

6 DATE OF BIRTH (month, day, and year) Jan 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	-	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) House Furnishings

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George W. Hoos (Address) 7007 Forest Park ave

15 Filed JAN 25 1921 Burial Permit [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1919, to Jan. 23rd, 1921, that I last saw him alive on Jan. 23rd, 1921, and that death occurred, on the date stated above, at 1-10 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (Cerebral)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) J. B. Schwatka, M. D.

19 (Address) 822 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 25 1921

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North ave

TION is very important. See instructions on back of certificates.

D 50197 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 321 N Fulton ST.; 19 WARD) 175-02

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yelverton P. Hobbs

(Residence in Baltimore: No. 321 N Fulton ave St.; yrs., 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Widower

6-DATE OF BIRTH, Oct (Month) 23 (Day), 1853 (Year)

7-AGE, 67 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 015
(b) General nature of industry, business, or establishment in which employed (or employer)..... Carpenter

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Caleb Hobbs

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ruth Hobbs

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry C. Hobbs

(Address) 1911 W Fayette st

15- Filed JAN 25 1921 ROBERT J. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Ins death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Hip & bruises & nervous shock

Auto accident

(Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) James M. Fenlon M. D. (Coroner.)

Jan 24, 1921 (Address) 700 E Chase st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Co	Jan 26, 1921
20-UNDERTAKER Joseph B. Cole	ADDRESS 1003 N. Ballo St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50198 HEALTH DEPARTMENT—CITY OF BALTIMORE D50198

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 E. Chase ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Lavery

(a) RESIDENCE. NO. 829 E. Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Lavery

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Barnard Hanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Ella Lavery 11. 829 E Chase St

15 Filed JAN 25 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1919 to 1-23 1921, that I last saw h[illegible] alive on 1-22 1921, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis 0 0 12

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) asthma

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Bernard Wass, M. D.

1/24. 1921 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 26, 1921
20 UNDERTAKER	ADDRESS
H C Warfield	914 Fremont Ave

HOW IS very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

D50199 HEALTH DEPARTMENT—CITY OF BALTIMORE D50199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3319 Piedmont ST.: 15 WARD) 150

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie L. Valentine

(Residence in Baltimore: No. 3319 Piedmont St.: yrs., 1 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. 29, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Steward

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Lillie M. Valentine

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie M. Valentine

(Address) 3319 Piedmont Ave

15-

Filed JAN 25 1921 ROBERT I KRAUTER

Burial Permit Issued. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

20

(Duration) ....yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) no history (Premature birth)

(Duration) ....yrs. 1 mos. 25 ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Jan. 24 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DW Auburn

DATE OF BURIAL, Jan 25, 1921

20-UNDERTAKER Daniel Corbett

ADDRESS 916 Pa ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050200

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050200

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital 37 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Butler

(a) RESIDENCE. NO. 509 N. Pamela ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daniel Easton
(Address) 916 Penn

15 Filed JAN 25 1927 ROBERT I KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1920 to Jan 23, 1921, that I last saw him alive on Jan 23, 1921, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystic Infection.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith, M. D.

1/24/1921 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MK Zion	Jan 25

20 UNDERTAKER Daniel Easton ADDRESS 916 Penn

FOR IMPORTANT INFORMATION see reverse side of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050201 HEALTH DEPARTMENT—CITY OF BALTIMORE 050201

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 E Fort Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gus L Lang

(Residence in Baltimore: No. 541 E. Fort Ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1890 (Year)

7-AGE, 30 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Oilerworker
(b) General nature of industry, business, or estsblishment in which employed (or employer): O.S.&

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Gus Lang

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Lehmann

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gus Lang

(Address) 541 E Fort Ave

15- Filed JAN 25 1921, 191.. ROBERT E KRAUTER Registrar. BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Jan 23 1921, that I saw h.im alive on Jan 23 1921, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Sidney H. Strauth, D.

Jan 25 1921 (Address) 1405 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, 1/26, 1921

20-UNDERTAKER John F Lahey & Sons ADDRESS 1318 Light St

D.50202 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50202

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 1205 Pulaski St. 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Donald Oconnor

(Residence in Baltimore: No. 1205 Pulaski (48 St.; yrs.,) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Oct (Month) 2 (Day), 1851 (Year)

7-AGE, 69 yrs. 3 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country) Washington D. C.

PARENTS.

10-NAME OF FATHER, Daniel O'Connor

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Susan O'Connor

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas O'Connor

(Address) 1709 E. Preston St.

15-

Received ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

JAN 25 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains, described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos Faulkner M. D.
(Coroner)

1-24-1921 (Address) 19 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 1-26, 19 21

20-UNDERTAKER Chas F. Wood & Son ADDRESS 118 W. Mt. Royal Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50203 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50203

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1004 E Chase ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philippine Bruel Bruel.

(a) RESIDENCE. NO. 1004 E Chase ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Sept 21. 1849

7 AGE: Years 71 Months 4 Days 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: 000

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacot Hornschuch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sophie Bruel.
(Address) 2109 Lynnhurst Ave

15 Filed Robert P. Harrison, Registrar

25 19.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jany 19th, 19 21, to Jany 23rd, 19 21, that I last saw h.... alive on Jany 23rd, 19 21, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1 Day

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Stone, M. D.

Jany 24 19 21 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Jan 27 19 21

20 UNDERTAKER: C. Herwig & Co

ADDRESS: 2008 Eleano

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50204 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50204

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S Bruce ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Little

(a) RESIDENCE. NO. 212 S Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14-1921

7 AGE Years Months Days: 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Philip Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Blanche Burkhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Blanche Little
(Address) 212 S Bruce St

15 Filed JAN 25 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Jan 24, 1921, that I last saw h.e.r. alive on Jan 24, 1921, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Illorris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem | DATE OF BURIAL: Jan 26 1921

20 UNDERTAKER: John J Fallon | ADDRESS: 1200 W Fayette

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50205 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D50205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1932 Orleans St. (St.:) 6 (Ward) 120

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Heid

(a) RESIDENCE. No. 1932 Orleans St. St., 6 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Kasper Heid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Heid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Kasper Heid
(Address) 1932 Orleans St

15 Filed JAN 25 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 23, 1921, that I last saw h. alive on Jan 22 1921, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Hypertension
Chronic Endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Findings

(Signed) F F Reynolds, M. D.

1-25. 1921 (Address) 508 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 26 1921

20 UNDERTAKER Lilly & Zeiler. ADDRESS 403 S. Wolfe St

Instructions on back of certificate. Read it very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50206

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 319 E. Biddle ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Kelly

(a) RESIDENCE. NO. 319 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 3 mos. ? ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Mohrlein

6 DATE OF BIRTH (month, day, and year) Oct. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	3	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool Sharpener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Timothy Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Margaret Kelly
(Address) 319 E. Biddle Street

15 Filed JAN 25 1921, 19 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1915, to Jan 24, 1921,
that I last saw him alive on Jan 20, 1921,
and that death occurred, on the date stated above, at 3.00 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 6 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? B.P. as high as 280

(Signed) Js. H. Wolterbeck, M. D.

Jan 25, 1921 (Address) 1310 Guilford Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans	1/26, 1921
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

THIS is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.50207

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.50207

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1013 Booth ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Albright

(a) RESIDENCE. No. 1013 Booth ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Joseph Albright

6 DATE OF BIRTH (month, day, and year) September 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hw. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Lem. Tasko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Tasker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Gross
(Address) 1023 Vine st.

15 Filed JAN 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 23 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1920, to Jan 23, 1921, that I last saw her alive on Jan 22, 1921, and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Pul Phthisis
Interstitial Pneumonia
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Feeney, M. D.

1/24, 1921 (Address) 710 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 26 1921
20 UNDERTAKER	ADDRESS 1140 W. Lombard
Brown & Sinclair	

IT IS VERY important. See instructions on back of certificate.

20.50208

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

X19-001

20 50208

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Kernans Hosp. ST. 25 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thyllis V. McClandlish

(Residence in Baltimore: No. 448 Mitchell Ave Hagerstown Md St.; 3 yrs. 6 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	

6 DATE OF BIRTH: July (Month) 15 (Day), 1917 (Year)

7 AGE: 3 yrs. 6 mos. 9 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Edw. McClandlish

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Gertrude Griffith

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. James

(Address) Kernan Hosp.

15.

Filed ..... 191 Robert P. Harrison, Registrar

JAN 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 24th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1921, to Jan 24th 1921, that I saw her alive on Jan 24th, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Heart failure
Pulmonary Embolism following
Chickenpox, Pox, unknown
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Infantile Paralysis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Franklin S. Anderson M. D.

Jan 24th, 1921 (Address) 10 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. 4 mos. 13 ds. In the State 3 yrs. 6 mos. 9 ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence: Hagerstown Md.

19 PLACE OF BURIAL OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Jan 26, 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,50209 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,50209

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1192 N. Calvert Road ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Miller

(a) RESIDENCE. NO. 1192 N. Calvert Road ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of John A. Miller

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	abt 67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Mattie Resau
(Address) 1329 Webster Street

15 Filed JAN 25 1921 Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25- 1921.

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Jan 25, 1921, that I last saw her alive on Jan 23, 1921, and that death occurred, on the date stated above, at 7.00 A m.

The CAUSE OF DEATH* was as follows:

OVER

Right Side Pneumophlegmea

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Wharland M. D.

(Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 27- 1921

20 UNDERTAKER William Cook ADDRESS 502 E North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic hemiplegia
due to arteriosclerosis.

Spec.—6-9-15—H. P. Co.—1000 Bks.

D.50210 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50210

CERTIFICATE OF DEATH. X 45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md General Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Lechrist.

(a) RESIDENCE. No. Westminster Md ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. Days mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lechrist

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant James M. Stoner
(Address) Westminster Md

15 JAN 25 1921

Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1921, to January 25, 1921, that I last saw him alive on January 25, 1921, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate (Carcinoma).

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? U.S. Date of Jan. 11, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory, Clinical Manifestation

(Signed) R. W. Richardson, M. D.

, 19 (Address) Md. Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	1/28/21
20 UNDERTAKER	ADDRESS
W M Cook	502 E Balto

How to fill out certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50211 HEALTH DEPARTMENT—CITY OF BALTIMORE D50211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 591

CITY OF BALTIMORE: (No. 1423 St. Matthews ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam'l. Mosley Anderson

(a) RESIDENCE. No. 1423 St. Matthews ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Anderson

11 BIRTHPLACE OF FATHER (city or town) Whaleyville (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) Whaleyville (State or country) Va.

14 Informant Robert Anderson (Father)
(Address) 1423 St. Matthews St.

15 Filed JAN 26 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 1 — 19, 1921, to 1 — 23, 1921, that I last saw h.. alive on 1 — 23, 1921, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) ~ yrs. ~ mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam + symptoms

(Signed) Ralph L. Young, M. D.

, 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 26 1921
20 UNDERTAKER	ADDRESS
Chris. N. Johnson	416 N. Caroline St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50212 OK D50212 NK Gonrich 138 coronor N.S

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 17 WARD)

2-FULL NAME Lucy Budd.

(a) RESIDENCE. No. 809 Fessier St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Budd

6 DATE OF BIRTH (month, day, and year) Mch. [illegible], 1890

7 AGE: Years 31; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Etta Bourgeois

13 BIRTHPLACE OF MOTHER (city or town) Howard (State or country) Co. Md

11 Informant Chas. Budd (Address) 809 Fessier St.

15 Filed JAN 26 1921 ROBERT P. BRAUNER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1921, to Jan. 22, 1921, that I last saw h[illegible] alive on Jan. 22, 1921, and that death occurred, on the date stated above, at 11.45 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy (nephritic)

(duration) yrs. mos. 3. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Not permitted

What test confirmed diagnosis? Clinical signs.

(Signed) Hans Eisenbrey M. D.

1/22 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem. DATE OF BURIAL: Jan. 26 1921

20 UNDERTAKER: Samuel Hemsley ADDRESS 578 Baltimore

Fold in only important. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50213

CERTIFICATE OF DEATH

REGISTERED NO. 15-40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 N Appleton ST., 15 WARD)

2-FULL NAME Samuel H Lamb

(a) RESIDENCE. No. 1803 N Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L Lamb

6 DATE OF BIRTH (month, day, and year): Sept 6 1868

7 AGE: Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): O'B

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary G Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant (Address): Mary L Lamb 1803 N Appleton St

15 JAN 26 1921 ROBERT F. KRAUTER Registrar

Baker 1100 N Eden St Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Jan 25, 1921, that I last saw h[illegible] alive on Jan 24, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach
Possibly Malignant
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Exhaustion
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. H. Bubert, M. D.

, 19 (Address) 1100 N. Eden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: Jan 27 1921

20 UNDERTAKER: Wm Bal 5026 Main | ADDRESS

IMPORTANT: See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50214 HEALTH DEPARTMENT—CITY OF BALTIMORE D50214

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 736 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Eyler

(Residence in Baltimore: No. 736 Bradley St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1891 (Year)

7-AGE, ... 30 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Dont know

11-BIRTHPLACE OF FATHER (State or Country) Dont know

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country) Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Taylor

(Address) 916 Pa ave

15-

Filed JAN 26 1921 ROBERT E. CRAUTON Registrar.
Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 24 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1921, to Jan 24 1921, that I saw h[illegible] alive on Jan 24 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage

..... (Duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Kemp M. D.

Jan 25, 1921 (Address) 1619 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Browns Death mf — DATE OF BURIAL, Jan 27, 1921

20-UNDERTAKER Daniel Taylor — ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

050215 HEALTH DEPARTMENT—CITY OF BALTIMORE 050215

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Home for Incurables V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Clark

(a) RESIDENCE. NO. 2001 E Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Clark

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis

(Address) 1411 E Baltimore

15 JAN 26 1921 ROBERT B. QUARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 24, 1921, that I last saw him alive on Jan 24, 1921, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Edema of the lungs

(duration) 6 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Zapffe, M. D.

1/25, 1921 (Address) 1210 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Rosedale	1/26 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050216 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050216

55-001 8427

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Fitch

(a) RESIDENCE. No. 604 Dilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 12, 1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
37	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener 186

(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Fitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER M McKeenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Henry Fitch (Address) 604 N. Dilton St.

15 Filed JAN 26 1921 ROBERT J. KLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 24 1921, that I last saw her alive on Jan 24 1921, and that death occurred, on the date stated above, at 1 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward L. Kaufman, M. D.

Jan 24 1921 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 26th 1921

20 UNDERTAKER Mr. & Mrs. John W. Penfel ADDRESS 84 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50217 HEALTH DEPARTMENT—CITY OF BALTIMORE D50217

CERTIFICATE OF DEATH. 108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 19 WARD)

2-FULL NAME Charles Lester Miller

(a) RESIDENCE. NO. # 1511 McHenry St. ST., ... WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-3-1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm G. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William G. Miller

(Address) 1511 McHenry St.

15 JAN 26 1921 ROBERT A. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug-15, 1920, to Jan-26, 1921, that I last saw him alive on Jan 26, 1921, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. 5 mos. 9 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home & hospital

Did an operation precede death? yes Date of Jan-24-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Woodruff, M. D.

, 19 (Address) Franklin Square Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 28 1921
20 UNDERTAKER Harry H. Witzke	ADDRESS 1531 W Lombard

Fill out all items. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50218 HEALTH DEPARTMENT—CITY OF BALTIMORE D50218

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.) (No. 11 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE. NO. 1610 Eutaw Place ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 - 21 - 39 4h

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Wesley Jones

11 BIRTHPLACE OF FATHER (city or town) Fort Wayne
(State or country) Indiana

12 MAIDEN NAME OF MOTHER Buddemeier

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant P. Artigiani - M. D.
(Address) Md. Gen'l Hosp.

15 Filed JAN 26 1921 ROBERT J. KLEJTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 21, 1921, that I last saw h[illegible] alive on Jan - 21, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Labor.

(Signed) Philibert Artigiani, M. D.

....., 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Child retained for scientific purposes	19
20 UNDERTAKER	ADDRESS

Read the instructions on back of certificate. Every item is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

050219 HEALTH DEPARTMENT—CITY OF BALTIMORE 050219

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH 514

CITY OF BALTIMORE: (No. 514 Conway ST.; 22 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucinda Sims

(Residence in Baltimore: No. 514 Conway St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknowned (Month), (Day), 1871 (Year)

7-AGE, 50 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 07

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Jessie Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknowned

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Thomas

(Address) 514 Conway St

15- [illegible]

Filed ..... 191.. [illegible] Registrar.

JAN 26 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Jan 22 1921, that I saw h[illegible] alive on Jan 22 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemo

(Duration) ... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. 1 mos. — ds.

(Signed) C. W. Thomas M. D.

Jan 22, 1921 (Address) 514 Conway St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Jan 26, 1921

20-UNDERTAKER Mrs Geo V. Hooper

ADDRESS 706 W. Conway St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50220

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 27 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Preston Kelley

(a) RESIDENCE. No. 533 Oakland ave., Govans Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? 66 yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Kelley

6 DATE OF BIRTH (month, day, and year) Dec 24-54

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary B. Kelley

(Address) 533 Oakland ave

15 Filed JAN 26 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 - 1921

17

I HEREBY CERTIFY, That I attended deceased from June. 11, 1921, to Jan. 25, 1921, that I last saw him alive on Jan. 25, 1921, and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis and Cholelithiasis

operation

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Jan 15, 1921.

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) [illegible] M. D.

1/25 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dear Island Somerset Co. Md	Jan 27 1921
20 UNDERTAKER Philip Herring	ADDRESS 2016 Arlington

Spec.—5-19-13—M. & T.—500 Bks.

D 50221

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 50221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Loach Lane ST.; 20 WARD) Calvert

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Washington Crawford

(Residence in Baltimore: No. 19 Loach Lane St.; 40 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	married

6-DATE OF BIRTH, ... May 3 ....., 1880
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 8 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Prince George Co Md

PARENTS.

10-NAME OF FATHER, John Crawford

11-BIRTHPLACE OF FATHER (State or Country), Prince George Co. Md.

12-MAIDEN NAME OF MOTHER Hattie Adams

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie A. Crawford

(Address) 19 Loach Lane

15- Filed JAN 26 1921 191... [illegible] Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 25th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 20 1921, to Jan 24th 1921, that I saw h... alive on January 24th 1921, and that death occurred, on the date stated above, at 2.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 6 yrs. ..... mos. ..... ds.

(Signed) Samuel Tarr M. D.

Jan 25th, 1921 (Address) 714 Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Star Cem	Jan. 28, 1921
20-UNDERTAKER	ADDRESS 114 N.
Brown & Packard	Schroder st.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D50222 ✓ D50222

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hamilton

CITY OF BALTIMORE: (No. 5212 Harford Road ST. W1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret S. Norwig

(a) RESIDENCE. NO. 5212 Harford Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of J Harry Norwig

6 DATE OF BIRTH (month, day, and year) October 26 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert L Struven

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Gebb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Albert L. Struven 5212 Harford Road

15 FILED JAN 26 1921 ROBERT J. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Jan 25 1921, that I last saw h alive on Jan 25 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia - Meningitis (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Blood stream infection (Staphylococcus aureus)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture.

(Signed) Claude Smith, M. D.

Jan 25, 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 27th 1921
20 UNDERTAKER George L Schilling & Sons	ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 50223 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 117 N. Exeter St

CITY OF BALTIMORE: (No. ~~Ear~~ ST.; 5 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Pollock

(a) RESIDENCE. No. 117 N. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	–	–	–

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aron Wasserman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Toby Pollock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Joseph Pollock 1218 E. Lexington St

15 Filed JAN 26 1921 19 ROBT. J. BRADY Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 25, 1921, that I last saw h[illegible] alive on Jan 25, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

H Hydrothorax
Hemorrhage

(duration) 3 yrs. – mos. 1 ds.

CONTRIBUTORY (Secondary) chron Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Boykin, M. D.

Feb. 1921 (Address) 210 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rendall Jan	26th 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Baltimore St

D50224

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Williams ST. 24 WARD) 120

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Albert Heryet

(a) RESIDENCE. No. 900 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22 1847

7 AGE	Years	Months	Days	if LESS than 1 day, ...hrs. or ...min.
	73	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 86

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edward Charles Heryet

11 BIRTHPLACE OF FATHER (city or town) Schleitz (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Elizabeth Rodney

13 BIRTHPLACE OF MOTHER (city or town) Kent Co Md (State or country)

14 Informant Mrs J. C. Armiger

(Address) 900 William St

15 JAN 26 1921 ROBERT J. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Jan. 23, 1921, that I last saw h im alive on Jan. 23, 1921, and that death occurred, on the date stated above, at 6a, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Vernon N. Condon, M. D.

, 19 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 28 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Gilmor

THIS IS very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D50225 HEALTH DEPARTMENT—CITY OF BALTIMORE D50225

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Frances Kaul.

(a) RESIDENCE. No. 2112 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	—	—	30	

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Adelaide Kaul.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Adelaide Kaul (Mother)
(Address) 2112 E. Lombard St

15 Filed JAN 26 1921 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1921, to Jan 26, 1921, that I last saw her alive on Jan 25, 1921, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal.

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) B MacPherson M. D.

1/26/1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan 26 1921

20 UNDERTAKER Lilly Zeiler

ADDRESS 1008 S. Wolfe

Spec.—6-9-19—H. P. Co.—1000 Bks.

050226 HEALTH DEPARTMENT—CITY OF BALTIMORE 050226

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Rose ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Doyle

(a) RESIDENCE. NO. 215 N. Rose ST., 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24th 1921

7 AGE	Years	Months	Days	If LESS than 1 day 15 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. B. Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Lucas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John H. B. Doyle (Father) 215 N. Rose St.

15 Filed JAN 26 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1921, to Jan 25, 1921, that I last saw h in alive on " " , 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

of seven & half

month (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. L. Beam M. D.

1/25, 1921 (Address) 2601 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 26th 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Mo[illegible]

Note.—Use black ink. Please write plainly. See instructions on back of certificates.

Males

D5022 HEALTH DEPARTMENT—CITY OF BALTIMORE D50227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 404 Park ave ST.: 4 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dally

(Residence in Baltimore: No. 404 Park Ave St.; Yrs., mos. ds.)

late

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Dont Know ..... (Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Parran Turner

(Address) 404 Park ave

15- JAN 26 1921 ROBERT E KRAUTER

Filed....., 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 1 (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any

(Duration) yrs. mos. ds.

(Signed) W K Gorman M. D. (Coroner.)

1-25, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel County

DATE OF BURIAL, Jan 26, 1921

20-UNDERTAKER Felix Pye

ADDRESS 102 E Baltimore St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050228 HEALTH DEPARTMENT—CITY OF BALTIMORE 050228

CERTIFICATE OF DEATH. 109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Allie Foster

(a) RESIDENCE. NO. 515 N. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Married~~ Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Virginia

PARENTS

10 NAME OF FATHER George W Bray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Bray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dunlaby Virginia

14 Informant Sidney Foster
(Address) 515 N. Schroeder St

15 Filed JAN 26 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Jan 24, 1921, that I last saw h alive on Jan 24, 1921, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (shock)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Jan 21, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman V. Abbott, M. D.

. 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	1-27-1921
20 UNDERTAKER	ADDRESS 517 N.
H. Brauning & Son	Schroeder St

Back of Certificates. See instructions on Back of Certificates.

D 50229 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50229

CERTIFICATE OF DEATH.

REGISTERED No. C 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Next door to Cor Low and Pitts St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Herbeck

(Residence in Baltimore: No. Next door to Cor. Low & High St.; yrs., 2 mos. ds.)

3 & 2 N. High St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.): Single

6-DATE OF BIRTH, ..., 1894
(Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): 05

9-BIRTHPLACE, (State or Country): Armenia

PARENTS.

10-NAME OF FATHER: Chas. Herbeck

11-BIRTHPLACE OF FATHER (State or Country): Armenia

12-MAIDEN NAME OF MOTHER: Lillian Christian

13-BIRTHPLACE OF MOTHER (State or Country): Armenia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. Herbeck
(Address) 667 N. Park Ave

15-
Filed JAN 26 1921 191.....
[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, au-topsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley M. D.
(Coroner.)
....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Phila. Pa.

19-PLACE OF BURIAL OR REMOVAL, Phila. Pa.

DATE OF BURIAL, Jan 31, 1921

20-UNDERTAKER George J. Smith

ADDRESS 1810 W. Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50230 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 D.50230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1939 Ramsay St. 20 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justine Bandell

(a) RESIDENCE. No. 1939 Ramsay St. 20 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Bernhardt Mandell

6 DATE OF BIRTH (month, day, and year): Feb. 26 1854

7 AGE: Years 66 Months 10 Days 29 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Saltzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Jane Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr Saltzman 1934 Ramsay

15 Filed 26 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from ... 19 20 to Jan 24 19 21.

that I last saw h... alive on Jan 24 19 21.

and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insuff

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. Schwenning, M. D.

, 19 (Address) 1120 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan 27 1921

20 UNDERTAKER: George J Smith — ADDRESS: Fayette

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Interstitial Nephritis

Spec.—8-24-14—M. & T.—2000 Bks.

D.50231 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50231

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1301 Hanover st. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Franklin Gardner

(Residence in Baltimore: No. 1301 Hanover st. St.: life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Oct. 12 ..... (Month), ... (Day), 1854. (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 3 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fisherman.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Nelson Gardner

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Charles Gardner.....

(Address)..1043 S. Sharp st.....

15-

Filed..... 191..... Robert P. Harrison, Registrar.

N261921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. 26/21. ..... (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2/20. 191..., to Jan. 26/21. 191..., that I saw him alive on Jan. 24/21. 191..., and that death occurred, on the date stated above, at 6. 45 m.

The CAUSE OF DEATH* was as follows: A. M.

.....

.....

..Chronic Paranchymatous Nephritis....

..... (Duration)..1...yrs..6....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

Jan. 26/ 191... (Address)..933 Hanover st.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Crisfield. Md.	Jan 27 ..., 191..
20-UNDERTAKER William Cook	ADDRESS 502 E. Main Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050232

HEALTH DEPARTMENT—CITY OF BALTIMORE

050232

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Stiegler

(a) RESIDENCE. No. Ellicott City, Md. WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 18, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Stiegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Stiegler (Address) 1115 W. Fayette

15 JAN 8 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921, to Jan 27, 1921, that I last saw him alive on Jan 27, 1921, and that death occurred, on the date stated above, at 3:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis. Edema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jerry D. Rob'ly, M. D.

1/27, 1921 (Address) Ellicott City, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 29 1921

20 UNDERTAKER: Scott M. Stark — ADDRESS: Ellicott City

BACK OF CERTIFICATE. SEE INSTRUCTIONS ON BACK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Koerner

(a) RESIDENCE. No. St Josephs Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Koerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Egelhofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm Henry Davidson 3711 Forest Park Ave

15 Filed JAN 27 1921 19 ROBERT I FEATHER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21 1921, to Jan 26 1921, that I last saw h[illegible] alive on Jan 26 1921, and that death occurred, on the date stated above, at 4.30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical findings

(Signed) Chas A Donovan M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 28 1921
20 UNDERTAKER	ADDRESS
Henry Street Son	1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Blks.

050234 HEALTH DEPARTMENT—CITY OF BALTIMORE 050234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. REGISTERED NO. 79

CITY OF BALTIMORE: (No. St Agnes Hosp. St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph Ostendorf

(a) RESIDENCE. No. 224 Park Ave St. 4 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? 57 yrs. 11 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Ostendorf

6 DATE OF BIRTH (month, day, and year) Feby-15-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor of

(b) General nature of industry, business, or establishment in which employed (or employer) Stationery & Religious Goods Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Clemente Ostendorf ? ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known ? ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Teresa Ostendorf (wife) (Address) 224 Park Ave

15 Filed JAN 27 1921 [redacted] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 26, 1921, that I last saw h[im] alive on Jan 25, 1921, and that death occurred, on the date stated above, at 8.00 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary infarct

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. W. K. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 28 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

FOR EARLY IMPORTANCE. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050235 HEALTH DEPARTMENT—CITY OF BALTIMORE 050235

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N Carrollton Av ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Elizabeth Charlotte Pritchard

(a) RESIDENCE. No. 911 N Carrollton Av ST., 16 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? 74 yrs 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irvin S. Pritchard

6 DATE OF BIRTH (month, day, and year) Jan 17 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Soule

11 BIRTHPLACE OF FATHER (city or town) Normandie
(State or country) France

12 MAIDEN NAME OF MOTHER Charlotte Lynch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Irvin L. Pritchard - (son)
(Address) 911 N Carrollton Ave.

15 JAN 27 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 25, 1921, that I last saw her alive on Jan 23, 1921, and that death occurred, on the date stated above, at a' m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart
to my knowledge since Jan 1920
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis Known of last 2 days
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W K Gorsuch, M. D.

1/25, 1921 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Jan 27/1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50236

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Virginia Fox

(a) RESIDENCE. No. 444 - E. North ST., 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? 56 yrs. 4 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Fox

6 DATE OF BIRTH (month, day, and year) Sep-14-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	56	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William S. Gill

11 BIRTHPLACE OF FATHER (city or town) Martinsburg (State or country) West Va

12 MAIDEN NAME OF MOTHER Ebella Spurry

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) Virginia

14 Informant Dr Geo. A. Fox - Husband (Address) North Gwynn Mount Ave

15 Filed JAN 27 1921 ROBERT I. REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/15 19.., to 1/26 19 21, that I last saw h.. alive on 1/26 19 21, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene Appendicitis

..... (duration) ... yrs. ... mos. 1. ds.

CONTRIBUTORY (Secondary) Arterio. Sclerosis.

..... (duration) (yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1/ 21

Was there an autopsy? Yes Operation Findings

What test confirmed diagnosis?

(Signed) ..... M. D.

1/ 28, 1921 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 28 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

How to fill out important. See instructions on back of certificates.

50237 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Eichin Bartlett & Hayward, or Mercy Hospital 64 ST.: 7 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Lemmere

(Residence in Baltimore: No. 762 McHenry St 54 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Feb (Month) 20 (Day), 1865 (Year)

7-AGE, 5-4 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Gas

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Jas. Lemmere

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Lemmere

(Address) 762 McHenry

15- Filed JAN 27 1921 191 ROBERT I. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Riley M. D. (Coroner.)

Jan 27, 1921 (Address) 1639 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	January 28 1921
20-UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50238 HEALTH DEPARTMENT—CITY OF BALTIMORE D50238

X114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Smith

(a) RESIDENCE. NO. New Windsor, Md. WARD. New Windsor Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Smith

6 DATE OF BIRTH (month, day, and year) 1877 - May - 19th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) of Cannery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Hank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Annie Smith, (Address) New Windsor, Md.

15 Filed JAN 27 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1921, to Jan. 26, 1921, that I last saw him alive on Jan. 26, 1921, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis - Operation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home New Windsor, Md.

Did an operation precede death? Yes Date of Jan 25, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. A. Dewey, M. D.

1/26, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pipe Creek Cemetery, Carroll Co., Md.	Jan. 30, 1921
20 UNDERTAKER	ADDRESS
C. M. Waltz,	Winfield, Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050239 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050239

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3736 Falls Road St.: 13 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jacob Glassmyer

(a) RESIDENCE. No. 3736 Falls Road Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Glassmyer

6 DATE OF BIRTH (month, day, and year) Jan 4 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 15

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sallie Glassmyer (Address) 3736 Falls Road

15 Filed JAN 27 1921 19 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 to 25 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to Jan 25, 1921, that I last saw him alive on Jan 25, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

R Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumococcus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical sign Pneumonia

(Signed) C. D. Carman, M. D.

1-27. 1921 (Address) 1702 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 28 1921

20 UNDERTAKER Chenowith Son ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50240

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 717 W 34 ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Leo Covahey

(a) RESIDENCE. NO. 717 W 34 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk At 009

(b) General nature of Industry, business, or establishment in which employed (or employer) Balto Bargain House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John F Covahey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary B McNiece

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary B Covahey

(Address) 717 W 34th St

15 Filed JAN 27 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920, to Jan. 26, 1921, that I last saw h.. alive on Jan. 26, 1921 and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. J. Covahey, M. D.

1-27, 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 31 1921

20 UNDERTAKER ADDRESS

Chenoweth Son Chestnut Ave

D50241 body sent to city morgue. HEALTH DEPARTMENT—CITY OF BALTIMORE D50241

CERTIFICATE OF DEATH.

156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 102 N. Paca St. ST.: 4 WARD) REGISTERED No. C.....

2-FULL NAME Frederick A. Hooper (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 102 N Paca St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Don't know

6-DATE OF BIRTH, ... Don't Know ....., 1..... (Month) (Day) (Year)

7-AGE, 53 about. Don't Know yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Laborer (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JAN 27 1921, 191.... ROBERT J. BRAUTIGAM Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan ..... 8 ....., 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) .....find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Inhalation

..... (Duration) ..... yrs. a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

..... (Duration) ..... yrs. a few hrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

1-8-, 1921 (Address) 1127 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

Commissioner Health. JAN 2 - 1921

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50242 D50242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 E Hoffman ST.; 8 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Thos. Jamie Cullison

(a) RESIDENCE. NO. 2005 E Hoffman ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ½ ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Cullison

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Peed

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Thomas Cullison
(Address) 2005 E Hoffman St

15 Filed JAN 27 1921 ROBERT S. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Jan 26, 1921, that I last saw h[illegible] alive on Jan 26, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth Congenital (6mos Foetus) Malformation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) S. P. Herzog MD, M. D.

Jan 26, 1921 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Jan 27 1921
20 UNDERTAKER	ADDRESS
Henry Lutz	1007 Bond St

L 50243 HEALTH DEPARTMENT—CITY OF BALTIMORE L 50243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hos. ST.: 19 WARD) REGISTERED No. C 187

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Brown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	unknown

6-DATE OF BIRTH, unknown (Month) (Day) 1 (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 67

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Filed JAN 27 1921 ROBERT J KRUSEN Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bullet wound through Kidney, Stomach, Liver, heart & lungs
Murder
(Duration) yrs. mos. 1/3 ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage
(Duration) yrs. mos. ds.

(Signed) James M Reuben M. D. (Coroner.)
Jan 21 1921 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Franklin St Hos In the State of death yrs. mos. 1/2 ds. yrs. mos. ds.

Where was disease contracted, if not at place of death? Seaboard St near Stricker

Former or usual residence unknown

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL — DATE OF BURIAL, JAN 26 1921

20-UNDERTAKER Commissioner Health, — ADDRESS

Important. See instructions on back of certificate.

morgue

B 50244 HEALTH DEPARTMENT—CITY OF BALTIMORE B 50244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5 N. Exeter ST.: 5 104 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No name - child of Alma Narer and Jack Voelker

(Residence in Baltimore: No. 5 N. Exeter St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 2 weeks ....yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jack Voelker

11-BIRTHPLACE OF FATHER (State or Country) U. S. (?)

12-MAIDEN NAME OF MOTHER Alma Narer

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alma Narer

(Address) 5 N. Exeter

15- JAN 27 1921 Filed ..... 191.. DOUGLAS I KRAUSE Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion
Acute Infantile Colitis
(Duration) ....yrs....mos....ds.
CONTRIBUTORY (Secondary) Prematurity Exhaustion
(Duration) ....yrs....mos....ds.

(Signed) W. S. Ryder M. D.
(Coroner.)
Jan 22 1921 (Address) 1020 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, JAN 26 1921, 19....

20-UNDERTAKER — ADDRESS

Commissioner of Health.

Important. See instructions on back of certificate.

Ludonia L. Mann

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50245

54

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 E. 22nd ST.; 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludonia Louise Mann

(a) RESIDENCE. No. 733 E. 22nd ST., WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Mann

6 DATE OF BIRTH (month, day, and year) Feb 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edgar Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Crook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Mann (Address) 733 E. 22nd St.

15 JAN 27 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1919, to Jan 25, 1921, that I last saw her alive on Jan 25, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Wm J Watson, M. D.

Jan 27, 1921 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jany 26 1921
20 UNDERTAKER	ADDRESS
J O Mitchell	1201 24 Fayette

Spec.—6-9-19—H. P. Co.—1000 Eks.

1950246

HEALTH DEPARTMENT—CITY OF BALTIMORE

1950246

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Larke

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital. JOHNS HOPKINS HOSPITAL

15 Filed JAN 27 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 23, 1921 to January 24 1921.

that I last saw him alive on January 23, 1921,

and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) R. H. Herman, M. D.

1/24/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 2[illegible] 1921

20 UNDERTAKER Commissioner Health,
per Wm. E. WOODALL

ADDRESS

IRON is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Blks.

050247

HEALTH DEPARTMENT—CITY OF BALTIMORE

050247

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Druid Hill Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE. NO. 915 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23-21

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Herman Johnson

11 BIRTHPLACE OF FATHER (city or town) Northumberland Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Janet Smith

13 BIRTHPLACE OF MOTHER (city or town) Northumberland Co
(State or country) Virginia

11 Informant Jane Johnson (mother)
(Address) 915 Druid Hill ave.

15 JAN 27 1921 ROBERT J. CRAWFORD
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1921, to Jan 23, 1921, that I last saw her alive on Jan 23, 1921, and that death occurred, on the date stated above, at 10 25 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Maternal Lues?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

1-24, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JAN 28 1921
20 UNDERTAKER Commissioner Health,	ADDRESS

This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50248 HEALTH DEPARTMENT—CITY OF BALTIMORE D50248

CERTIFICATE OF DEATH.

4 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 738 N Lexington ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Marston

(a) RESIDENCE. NO. 738 N Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Marston

11 BIRTHPLACE OF FATHER (city or town) Mt. Jackson
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Zetta Fleming

13 BIRTHPLACE OF MOTHER (city or town) Mt Jackson
(State or country) Virginia

14 Informant
(Address)

15 Filed JAN 27 1921 19 ROBERT P. PRATTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 25, 1921, that I last saw him alive on Jan 24, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Lues?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JAN 26 1921 19
20 UNDERTAKER Commissioner of Health, per Wm. E. WOODALL	ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

050249 HEALTH DEPARTMENT—CITY OF BALTIMORE 050249

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Central Ave St.; 10 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Anna Etzel

(Residence in Baltimore: No. 1036 Central Ave St.; Lifetime yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, ✓ MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, January (Month) 17 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Andrew Etzel

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Norwood.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Etzel

(Address) 1036 N. Central Ave

15- [redacted] I KRAUTER

Filed JAN 27 1921 191.... Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 27 1921, that I saw her alive on Jan 26 191..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F. Vaeglem M. D.

Jan 27, 1921. (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, 1/27, 1921

20-UNDERTAKER Chas. F. Wood & Son — ADDRESS 118 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D50250 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D50250

D50250

CERTIFICATE OF DEATH.

REGISTERED NO. C 15 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 Walbrook Ave., St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Whittington

(Residence in Baltimore: No. 2230 Walbrook Ave., St.; 8 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, September 12th, 1837 (Month) (Day) (Year)

7-AGE, 83 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ------ Whittington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER ------ Jones

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm A Smith

(Address) 2230 Walbrook Ave.

15- JAN 27 1921 Filed....., 191... ROBERT F KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 26th, 1921 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I attended deceased from Jan 19th, 191... to Jan 26, 1921 191..., that I saw her alive on Jan 26, 1921 191..., and that death occurred, on the date stated above, at 12 h pm.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ....yrs. 1 mos. ....ds.

(Signed) J B Culbertson M. D.

1/27/21, 191... (Address) 1800 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Jan 28, 1921.
20-UNDERTAKER W M Routson	ADDRESS 2235 W Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 50251 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 E Calhoun St.; 19 WARD) REGISTERED NO. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma C. Rice

(Residence in Baltimore: No. 212 E. Calhoun St. St. Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb 25, 1862
(Month) (Day) (Year)

7-AGE. 59 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert Rice

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Guellich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hurley

(Address) 212 E. Calhoun St.

15- Filed JAN 27 1921 ROBERT F. KRAUTER Registrar.
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23. 1921, to Jan 25, 1921, that I saw her alive on Jan 25, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) yrs. 14 mos. ds.

(Signed) J. B. Wilson M. D.

1926, 1921 (Address) 1735 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peter	Jan 29, 1921
20-UNDERTAKER John J Fields	ADDRESS 1200 W Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

D50252 HEALTH DEPARTMENT—CITY OF BALTIMORE D50252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2450 Buchanan ST.; 17 WARD) REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Page.

(Residence in Baltimore: No. 2450 Buchanan St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Afro american

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Jany (Month) 25 (Day), 1843 (Year)

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Stephen Bowels.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Agnes —

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Madison

(Address) 2450 Buchanan St.

15- Filed JAN 27 1921, 191... [illegible] REGISTER. Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1920, to Jany 24 1921, that I saw her alive on Jany 24, 1921, and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial

Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hugh Forsythe M. D.

Jan. 26, 1921. (Address) 1246 North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Almas C. Shawan & Co. DATE OF BURIAL, Jan 21st, 1921.

20-UNDERTAKER Geo. H. Holland ADDRESS 1631 Monroe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050253 HEALTH DEPARTMENT—CITY OF BALTIMORE. 1050253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD) 28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson (Priscilla Coates)

(a) RESIDENCE. No. 812 Bruce st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 27 1921 . 19 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 19 21, to Jan. 25, 19 21, that I last saw her alive on Jan. 24, 19 21, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. H. Fahnestock, M. D.

1-25-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan. 27 1921

20 UNDERTAKER Edw. Ringgold ADDRESS 1463 Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

K50254

HEALTH DEPARTMENT—CITY OF BALTIMORE

K50254

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Moore.

(a) RESIDENCE. No. Unknown. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Black.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unk (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unk (State or country)

14 Informant Records.

(Address) City Hospital, Bay View

15 Filed JAN 27 1921 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1919, to Jan. 25, 1921, that I last saw h ll alive on Jan. 25, 1921, and that death occurred, on the date stated above, at 11 30 A.m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis of aorta.

(duration) ? yrs. mos. ds.

18 Where was disease contracted ? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann.

(Signed) V. Bethman., M. D.

Jan 26 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Md	Jan 28 1921
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey

Spec.—8-24-14—M. & T.—2000 Bks.

D50255 HEALTH DEPARTMENT—CITY OF BALTIMORE D50255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2076 24th St.; 12 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Innes

(Residence in Baltimore: No. 2076 E. 24th St St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 1, 1875 (Month) (Day) (Year)

7-AGE, 45 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Allen Hunt

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Isabella Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Artie Peters

(Address) 2076 E 24th St

15- JAN 27 1921 Filed ....., 191.... ROBERT J. KRAUTER Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Jan 25 1921, that I saw h[illegible] alive on Jan 25 1921, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Lesion

(Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. J. Coleman M. D.

Jan 27, 1921 (Address) 2037 Eliza St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Farmville Va Va — DATE OF BURIAL, Jan 29, 1921.

20-UNDERTAKER Wm R A Elliott ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50256 HEALTH DEPARTMENT—CITY OF BALTIMORE 40 D50256

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 353 S.Fulton Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur T.Maben,

(a) RESIDENCE. NO. 353 S.Fulton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta A. Maben,

6 DATE OF BIRTH (month, day, and year) October 26.1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer) Morgan Mill Co.

(c) Name of employer Morgan Mill Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James A,Maben,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Carrie A.Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Augusta A Maben (Address) 353 S.Fulton Ave

15 Filed JAN 27 1921 [illegible] Registrar

Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.26.1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Jany 26, 1921, that I last saw h[illegible] alive on Jany 26, 1921, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Thos R. Edeen, M. D.

Jan 27, 1921 (Address) 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Jan.29.1921

20 UNDERTAKER Geo W Little ADDRESS 531 N. Fremont Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50257 HEALTH DEPARTMENT—CITY OF BALTIMORE D50257

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 2909 Brighton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Young,

(a) RESIDENCE. No. 2909 Brighton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 5. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Julia Lynch,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Easter

(Address) 2909 Brighton St

Date JAN 27 1921 19 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Jan 27", 1921, that I last saw her alive on Jan 26" 1921, and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Herbert E. Easter, M. D.

1/27 1921 (Address) 3050 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Jan 29 19 1921

20 UNDERTAKER Geo W Little ADDRESS 531 N. Fremont

Joseph Frankowski.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D50258 HEALTH DEPARTMENT—CITY OF BALTIMORE D50258

CERTIFICATE OF DEATH 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Durham ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Frankowski

(a) RESIDENCE. NO. 715 S Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Frankowska.

6 DATE OF BIRTH (month, day, and year) Feby 2- 1844.

7 AGE: Years 76 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Ignacy Frankowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Anna Klenkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Katharine Frankowska. Wife 715 S. Durham St.

15 Filed JAN 27 1921 19 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1921, to Jan 25 1921, that I last saw h— alive on Jan 25, 1921 and that death occurred, on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

1/26/21 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Comm.

DATE OF BURIAL: Jany 27 1921.

20 UNDERTAKER: M. F. Sadowski.

ADDRESS: 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

D50259 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D50259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 611 S. Ellwood Ave., St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie A. Russell

(Residence in Baltimore: No. 611 S. Ellwood Ave., St.: 1y. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Jan 21st, 1898 (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
23 yrs. 4 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Not employed
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Patrick Russell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Pfeifer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Swift

(Address) 611 S. Ellwood Ave.

15- ROBERT I. KRAUTH

Filed JAN 27 1921 191... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 25th, 1921 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 18th, 191 0, to Jan 25th, 1921, that I saw her alive on Jan 25th, 1921, and that death occurred, on the date stated above, at 10:15P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis T.B.

(Duration) 5 yrs. mos. ds.

(Signed) F. E. Culbertson M. D.

1/25/21, 191... (Address) 1800 Linden Ave.,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oaklawn	Jan 29 191 21
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager

Important: See instructions on back of certificate.

20.50260

HEALTH DEPARTMENT--CITY OF BALTIMORE

20.50260

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 503 Park Ave ST.) 79 (WARD)

REGISTERED NO. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Washington

(Residence in Baltimore: No. 131 W. Preston St.: 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Don't Know, 1 (Month) (Day) (Year)

7 AGE: 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Servant
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9 BIRTHPLACE (State or country): Va.

PARENTS

10 NAME OF FATHER: Don't Know.

11 BIRTHPLACE OF FATHER (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David A. Washington

(Address) 31 W. Preston St.

15 Filed JAN 27 1921, 191

Robert P. Harrison,
Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. 27, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1920, to Jan 27 1920, that I saw h.. or alive on Jan 27, 1920, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Chronic Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene Hargrove M. D.

Jan 27, 1920 (Address) 803 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Gloucester - Va.

DATE OF BURIAL: Jan 28 - 1920

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 E. North Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

4 OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50261 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50261

CERTIFICATE OF DEATH.

127-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Christian Mooyer

(a) RESIDENCE. No. 1948 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Christian Mooyer

6 DATE OF BIRTH (month, day, and year) Dec. 29, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mr. George Mooyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Mooyer (Address) 1948 N. Gay St.

15 Filed JAN 27 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1921, to Jan. 27, 1921, that I last saw him alive on Jan. 26, 1921, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia. (3 days)

Bronchopneumonia. (2 days)

(duration) yrs. mos. 2 wks.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of Jan 25-21

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) H. H. Tamponbarni, M. D.

Jan 27 1921 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery.	Jan 31. 1921

20 UNDERTAKER Wm. Cook

ADDRESS 5329 North Ave

ATION IS very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for Hydrocele
Cord

Spec. 6-9-19—H. P. Co.—1000 Bks.

1050262 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050262

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 937 Forrest St- ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Lundburg

(a) RESIDENCE. No. 937 Forrest St- ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas J Lundburg

6 DATE OF BIRTH (month, day, and year) Feb. 14/1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisonburg Va.

PARENTS

10 NAME OF FATHER John Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Catherine Ervine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lillie Walsh

(Address) 937 Forrest St-

15 Filed Jan 27/21 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 18- 1921, to Jan. 25 1921, that I last saw h.er alive on January 25 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Coma

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby M. D.

1/29/1921 (Address) 1223 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan. 28 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E. Pleasant

TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 10 120

(If death in a hospital or institution, give number instead of street.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Fourth ST.: 10 WARD)

2-FULL NAME Eliza Jane Hamburg.

(a) RESIDENCE. No. 937 Fourth ST., WARD.
(Usual place of abode) (If nonresident give city or town)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. F. Lumburg.

6 DATE OF BIRTH (month, day, and year) Feb. 14. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John Bair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catharine Ensz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Lillie Walsh
(Address) 937 Fourth St.

15 Filed , 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2

17 I HEREBY CERTIFY, That I attended Jan. 18, 1921, to Jan. 2
that I last saw her alive on January 2
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Chronic Brights dise
Large white Kidney

Uncertain (duration) yrs.

CONTRIBUTORY (Secondary) Coma

(duration) yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Edwin B. Fahr

1/26/1921 Address 1223 N. Caroline

*State the Disease Causing Death, or in deaths from state (1) Means and Nature of Injury, and (2) whet Suicidal, or Homicidal. (See reverse side for additional s

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DA

20 UNDERTAKER Wm Cook AD

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50263 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50263

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 170 S. Duncan. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Barnikel

(a) RESIDENCE. No. 170 S. Duncan. ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs mos. ds. How long in U. S., if of foreign birth? 50 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of P. Barnikel.

6 DATE OF BIRTH (month, day, and year): Oct. 17-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Barnikel.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Barbara Fetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Joseph Fischer. (Address) 170 S. Duncan St.

15 Filed JAN 27 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/19, 19 21, to 1/25, 19 21, that I last saw h. alive on 1/24, 19 21, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Frame, M. D.

1/26, 19 21 (Address) 2934 W. Eldern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 28 19
20 UNDERTAKER: Tilly & Zitler.	ADDRESS: 403 S. Broadway

TION is very important. See instructions on back of certificates.

20.50264 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50264

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 20 E. Weber Stl ST. 23 79 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Bowley.(C)

(Residence in Baltimore: No. 20 E. Weber St. 56 -- --- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH,

.....Do not know....., 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
73 yrs. ---------- mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),
Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Spence.(C)son.

(Address) 20 E. Weber St.

15-

Filed JAN 27 1921, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...January 26th. 1921....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...inquiry.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) inquiry .....find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Organic disease of the heart and
Kidneys.
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jan 27., 1921 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	JAN 27, 1921, 19....
20-UNDERTAKER	ADDRESS
Commissioner Health,	

WM. F. WOODALL

CAUSE OF DEATH: Item 17 is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50265 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50265

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sullivan

(a) RESIDENCE. NO. #732 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Structual Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 19

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Ellen Edwards

(Address) Pleasant Plain Ill.

15 Filed JAN 27 1921 Robert P. Harrison, Registrar

Penn. R. Burial Permit Clerkindd - Escort

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 24, 1921, that I last saw him alive on Jan 24, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2, ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Keyes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensburg Green Co. Ky.	1/27/21, 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	Calvert

FOR is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50266

37

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Lutsche

(a) RESIDENCE. No. 229 Gilmor st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records
(Address)

15 Filed JAN 27 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to Jan 26, 1921, that I last saw h.. alive on Jan 26, 1921, and that death occurred, on the date stated above, at 7:45 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & serological Tests

(Signed) G. C. Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL. Cem.	JAN 29 1921
20 UNDERTAKER	**ADDRESS**
JOHN F. DENNY	715 LIGHT ST.

ATION is very important. See instructions on back of certificates.

D.50267 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50267

CERTIFICATE OF DEATH. 175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S. Lee

(Residence in Baltimore: No. 216 E. Eager St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April 26, 1866
(Month) (Day) (Year)

7-AGE. 54 yrs. 8 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, J. S. Lee

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Julia Scott

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Lee

(Address) 216 Eager

15- JAN 27 1921 Robert P. Harrison,
Filed....., 191.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, ~~autopsy or~~ inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, ~~au~~topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull -
Collided with Automobile
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. J. Daley M. D.
(Coroner.)
Jan 26, 1921. (Address) 1639 Bust

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery
DATE OF BURIAL, Jan. 29, 1921

20-UNDERTAKER Henry W. Mears & Son
ADDRESS 805 N Calvert St

important. See instructions on back of certificate.

D.50268 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hosp. ST. 17 WARD) REGISTERED NO. C 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rodosa

(Residence in Baltimore: No. 1048 Pennsylvania St.; yrs. 4 mos. 9 ds. 17)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, April 9, 1916 (Month) (Day) (Year)

7-AGE, 4 yrs. 9 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none (child)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Stevenson Rodos

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Eliz. Bellos

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephenson Rodos

(Address) 1048 Penn Ave.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

127102 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second degree burns of body. (accident) (2 hrs)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. A. R. Hennessy M. D. (Coroner)

Jan. 27, 1921 (Address) 2802 E. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1048 Penn. Ave.

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Jan. 28, 1920

20-UNDERTAKER Daniel Carbon ADDRESS 916 Penn

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Holly

D.50269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50269

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Hargrove alley St.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Holly

(Residence in Baltimore: No. 405 Hargrove Alley St.; 26 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, not known, (Month) (Day) 1896 (Year)

7-AGE, 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country) Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pacific

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 25th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 25th 1921, to January 25th, 1921, that I saw h[illegible] alive on January 25th 1921, and that death occurred, on the date stated above, at 5.35 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. Hours mos. ..... ds.

(Signed) W. H. Holland M. D.

January 26th, 1921. (Address) 602 N Thurston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 28 1921.

20-UNDERTAKER Daniel Easton — ADDRESS 916 Pacific

20.50270 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50270

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 6 WARD)

2-FULL NAME Charles Kerr Humphreys

(Residence in Baltimore: No. 417 N. Broadway St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, July (Month) 23 (Day) 1857 (Year)

7-AGE, 63 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Rev. W. Humphreys

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Charlotte Jane

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarv Zipf

(Address) 417 Bway

15- Robert P. Harrison,
Filed JAN 27 1921, 191.....
Registrar.
Burial Permit Clerk.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 25 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull — Caused by a Fall in an effort to avoid collision with 2 automobiles

.....Fulton (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed).....M. D. (Coroner.)

Jan 27 1921 (Address) 16 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	January 28 1921
20-UNDERTAKER	ADDRESS
H. E. Hughes	1st & Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50271 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50271

CERTIFICATE OF DEATH. 4 X 53

1-PLACE OF DEATH REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Snyder (George Snyder)

(a) RESIDENCE: NO. Roslyn Md ST., ... WARD. Roslyn Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wilhelmina Snyder

6 DATE OF BIRTH (month, day, and year) Jan 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catharine Kopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Stephens Record
(Address)

15 Filed JAN 27 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1921, to Jan. 27 1921, that I last saw h.. alive on Jan. 27 1921, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia
Myocarditis

..... (duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of neck

..... (duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? At home Roslyn, Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm. Osler, M. D.

1/27 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet, Roslyn Md	Jan 30" 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50272 1447/72

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50272 64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

2-FULL NAME. Lizzie Patterson

(a) RESIDENCE. No. 176 W. Lanvale St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record

(Address) [illegible]

15 Filed ..... 19 Robert P. Harris Registrar

JAN 27 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 18, 1920, to Jan 26, 1921, that I last saw h[illegible] alive on Jan 26, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 0 yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 20 yrs. 3 mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of none

Was there an autopsy? yes

What test confirmed diagnosis? Spinal Puncture

(Signed) Henry A. Thomas Jr. M. D.

1-27, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan 29 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Brohawn)

Spec.—8-24-14—M. & T.—2000 Bks.

D.50273 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hollins Ferry Rd. Lakeland ST.; 25 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Edward Brohawn

(Residence in Baltimore: No. Hollins Ferry Rd. Lakeland. St.; 46 yrs.,.....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and old state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, December (Month) 12th. (Day), 1845. (Year)

7-AGE, 75 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Dorchester County, Md.

PARENTS.

10-NAME OF FATHER, Edward Brohawn

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Jennie M. Morris

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida E. Basken

(Address) Hollins Ferry Rd. Lakeland Baltimore

15-

Filed....., 191.....

JAN 27 1921

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 27, (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1920, to Jan. 27 1921, that I saw him alive on Jan. 27 1921, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ? yrs. mos. ds.

(Signed) Thaneus Wheeler M. D.

Jan 27, 1921. (Address) Lakeland, Balto. Co.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Jan 29th, 1921.

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1050274 1050274 1050274

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 N. Edon ST.: 10 WARD)

2-FULL NAME Dr. Edward & Helen M. Egenhoffer

(a) RESIDENCE. No. 1042 N. Edon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George A Egenhoffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen May Grossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George A Egenhoffer

(Address) 1042 N Edon

15 Filed JAN 28 1921, 19 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921 to Jan 25, 1921.

That I last saw him alive on Jan 25, 1921.

and that death occurred, on the date stated above, at 9:25 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

about 5 months

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Isaac M. D.

1/26, 1921 (Address) 413 B Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Johns Hopkins Med School	
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

A50275

HEALTH DEPARTMENT—CITY OF BALTIMORE

A 50275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Park Ave ST.: 4 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Philip Hildebrandt

(a) RESIDENCE. NO. 306 N. Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Florence J. Hildebrandt

6 DATE OF BIRTH (month, day, and year) DEC 21-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Designer

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas H. Hildebrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary C. Helm

13 BIRTHPLACE OF MOTHER (city or ~~town~~) (State or country) Baltimore Md.

14 Informant Frances L. Gaither

(Address) 1013 Poplar Grove St.

15 FILED JAN 28 1921 ROBERT E. LAZTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1920, to Jany 27, 1921.

that I last saw him alive on Jany 26, 1921.

and that death occurred, on the date stated above, at 6.55a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ✓ yrs. 7 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary Analysis

(Signed) George C. Shannon, M. D.

1/27 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Jan 29 1921
20 UNDERTAKER Robert Brockerson	ADDRESS Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Thomas Mathews

050276 HEALTH DEPARTMENT—CITY OF BALTIMORE 050276

CERTIFICATE OF DEATH. X175-003

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 34 Jeff Hospital 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Mathews

(Residence in Baltimore: No. Philadelphia Penn Str. yrs. mos. ds.)

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH, April (Month) (Day) 1905 (Year)

7-AGE, 15 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER Wm J. Mathews

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura E. Mathews

(Address) Philadelphia Pa.

15- JAN 28 1921 Filed ....., 191.... ROBERT J. [illegible] Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Infection of Arm (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Phila. Pa.

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa. DATE OF BURIAL, Jan. 28, 1921.

20-UNDERTAKER Wm E. Black ADDRESS 927 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

150277

HEALTH DEPARTMENT—CITY OF BALTIMORE

150277

CERTIFICATE OF DEATH.

152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 S East av. St.: 20 WARD)

2-FULL NAME John Herman Oehm

(a) RESIDENCE. No. 16 S East av St., 20 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H. Oehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Edna E. Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John H. Oehm
(Address) 16 S East av

15 Filed JAN 28 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/24/21, 19..., to 1/28/21, 19...,
that I last saw h... alive on ..., 19...,
and that death occurred, on the date stated above, at 8.30 p.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Trauma (duration) ... yrs. ... mos. 3 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. Herman C., M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 28 21
20 UNDERTAKER	ADDRESS
Louis Heemann	326 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

~~Dec~~ Injury at Birth.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050278

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050278

CERTIFICATE OF DEATH.

X92-079

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Larkins.

(a) RESIDENCE. No. Ella Md. ST., WARD. Ella Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~—~~ yrs. ~~—~~ mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Clifford Larkins

6 DATE OF BIRTH (month, day, and year) Aug 27/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30.	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(e) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Silas Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Ebaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Larkins (Address) 1 Maine st (Arlington)

15 JAN 28 1921 ROBERT P. LAMONT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1921, to Jan 27, 1921, that I last saw her alive on Jan 27, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation preeede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Seyer, M. D.

Jan 27 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 31 1921

20 UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR STATISTICS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050279 HEALTH DEPARTMENT—CITY OF BALTIMORE 050279

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 20 REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Marburg, Jr. A.

(a) RESIDENCE. NO. Washington Apts, Mt. Vernon Place ST., WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 34 yrs. 8 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. William Marburg, Jr. A (Virginia Hack Marburg)

6 DATE OF BIRTH (month, day, and year) May 27, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Co

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Marburg.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie G. Gardner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Malbert Marburg (father) (Address) 11 E Chase St

15 Date Received JAN 28 1921 ROBERT I. BEAUTE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from December 31st, 1921, to January 27th, 1921, that I last saw him alive on January 27th, 1921, and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Abscess, 1st + 3rd molars, lower, left.

(Stop for cause, primary.)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Abscess, parotid + sub-maxillary, left. General septicaemia (Staph. aureus)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of Jan 3rd + 5

Was there an autopsy?

What test confirmed diagnosis? Operation + blood culture

(Signed) J. M. Hennessy Jr., M. D.

Jan 27, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Jan-29-1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050280 HEALTH DEPARTMENT—CITY OF BALTIMORE 050280

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH Abbottston REGISTERED NO.

CITY OF BALTIMORE: (No. Gorsuch ave. (Ward) ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte abbott Cate.

(a) RESIDENCE. NO. Abbottston - Gorsuch Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Isaac M Cate.

6 DATE OF BIRTH (month, day, and year) 1842-4-27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady at Home. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Horace Abbott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sudbury Mass

12 MAIDEN NAME OF MOTHER Charlotte Hapgood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Shrewsbury Mass

14 Informant Horace Cate (Address) Abbottston - Gorsuch Ave

15 FILED JAN 28 1921 ROBERT B. ELLICOTT Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 26, 1921, that I last saw her alive on Jan 26, 1921, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary.

(Signed) Fred Wertho Jr. M. D.

1/27 1921 (Address) 2020 N. Charles St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 29 1921
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Son Co	Oakland 1100 Collord St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50281

CERTIFICATE OF DEATH.

REGISTERED NO. C 1172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Holt

(Residence in Baltimore: No. 911 N Charles St St.; ...yrs.,..mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) (Day) 1841 (Year)

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel Holt

11-BIRTHPLACE OF FATHER (State or Country), Conn

12-MAIDEN NAME OF MOTHER Ann Scherbet

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Joseph C Blondgood

(Address) Roland Park

15-

Filed JAN 28 1921 ROBERT P. PROCTOR Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1921, to Jan 27 1921, that I saw h e alive on Jan 27 1921, and that death occurred, on the date stated above, at 6.15A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Fractured Femur – Plaster Cast

(Duration) ...yrs. ...mos. 8 ds.

(Signed) Francis Worthington M. D.

Jan 28, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 8 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence 911 N. Charles St. Balto, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	January 29 1921
20-UNDERTAKER	ADDRESS
Henry H. Jenkins & Sons Co	Exclusive Funeral Home 847 N. Eutaw St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Accidental - Fall down stair at her home

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50282 HEALTH DEPARTMENT—CITY OF BALTIMORE D50282

CERTIFICATE OF DEATH. X 8-04

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 713 N Eden ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Sumler

(a) RESIDENCE. No. 713 N Eden ST., WARD. Raleigh N C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residance in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh NC

PARENTS

10 NAME OF FATHER Henry Sumler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh NC

12 MAIDEN NAME OF MOTHER Addie Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh NC

14 Informant Henry Sumler

(Address) 713 N Eden St

15 Date Received JAN 28 1921

OBERT E REUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Jan 27, 1921, that I last saw h[illegible] alive on Jan 26, 1921, and that death occurred, on the date stated above, at 7 am m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) 0 yrs. 0 mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edw Fisher M. D.

1-27 1921 (Address) 1617 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan 28 1920
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50283 D 50283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 40

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.....

CITY OF BALTIMORE: (No. North Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William H. Miller

(a) RESIDENCE. NO. Gambrills, Md ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Miller (wife)

6 DATE OF BIRTH (month, day, and year) Mar. 10- 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Minnie Miller
(Address) Gambrills Md.

15 Filed JAN 28 1921 ROBERT B. KRAUTER Registrar
Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan, 17, 1921. to Jan 27, 1921.

that I last saw him alive on Jan 27, 1921.

and that death occurred, on the date stated above, at 6 00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
with metastases

4 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) W. D. Noble, M. D.

(Address) Church Home & Infirmary Jan 27 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 29 1921
20 UNDERTAKER	ADDRESS
Mc Nus J. W. Zeufel & Son	801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50284 HEALTH DEPARTMENT—CITY OF BALTIMORE D50284

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Oskins

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JAN 28 1921 ROBERT J. KANTER Registrar Board Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to January 26, 1921.

that I last saw her alive on January 26, 1921.

and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B Hoffman, M. D.

1/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 29 1921
20 UNDERTAKER	ADDRESS
H. Vander & Son	1710 Pleasant

So 786-W

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50285

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 Hanover ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hubbard

(a) RESIDENCE. NO. 1339 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 5 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary E Hubbard

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marines

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pernetta M Schlefferlings
(Address) 1339 Hanover St

15 JAN 28 1921 REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from ?, 1910, to Jan 27, 1921, that I last saw him alive on Jan 26, 1921, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) 2 years yrs. mos. days ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) GE Burton, M. D.

1.28. 1921 (Address) 304 E. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Jan 29 1921
20 UNDERTAKER	ADDRESS
E. Schloman & Son	1039 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Haemorrhage

Spec.—8-24-14—M. & T.—2000 Bks.

Lochner

050286

HEALTH DEPARTMENT—CITY OF BALTIMORE

050286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 558 North Gay ST.; 5 WARD) 150

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rubin Lochner

(Residence in Baltimore: No. 558 North Gay St.; ....yrs., 8 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October 15, 1920
(Month) (Day) (Year)

7-AGE, — 3 — yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John R Lochner

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Matilda Lochner

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine Feher

(Address) 558 N Gay St

15-

Filed JAN 28 1921 ROBT. J. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15 1920 to Jany 25 1921, that I saw him alive on January 27 1921, and that death occurred, on the date stated above, at 750 a m.

The CAUSE OF DEATH* was as follows:

Catarrhal Ileus of the bowel
was a Premature Birth
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY. (Secondary) Catarrhal Ileus of bowel
(Duration) Lifetime yrs. ....mos. ....ds.

(Signed) H. Young Wheelbrain M. D.

Jany 28, 1921 (Address) 1618 Goucher ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Jan. 29, 1921

20-UNDERTAKER Henry Hoerdt Son — ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50287

CERTIFICATE OF DEATH.

8-09

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.; ..... WARD)

2-FULL NAME Charles Wagner

(a) RESIDENCE. No. 1621 Faith Lane ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) aug. 14-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Raymond Jerrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Alice Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant
(Address) Robert P. Harrison. JOHNS

15 [illegible] 19

JAN 28 1921

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Jan 26, 1921, that I last saw him alive on Jan 26, 1921, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7(?) ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B Wagoman M. D.

1/26/1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JAN 2 19

20 UNDERTAKER

ADDRESS

For, WM. E. WOODALL.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50288 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50288

CERTIFICATE OF DEATH. 21 152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Brisco ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hunt

(a) RESIDENCE. NO. 1129 Brisco ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Wilkerson

11 BIRTHPLACE OF FATHER (city or town) Caroline
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Susan Davis

13 BIRTHPLACE OF MOTHER (city or town) Victoria
(State or country) Virginia

14 Informant Susan Hunt (mother)
(Address) 1129 Brisco St

15 Filed JAN 28 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1921, to Jan 27, 1921, that I last saw him alive on Jan 27, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Morris Reese, M. D.

Jan 28 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS JAN 28 1921
Commissioner Health.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50289 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50289

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gmrral Hosp. ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa M. Hines

(a) RESIDENCE. NO. 1211 Johns ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? 76 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse K. Hines

6 DATE OF BIRTH (month, day, and year) Oct. 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs Katherine H. Gundry (Address) Catonsville Md

15 Filed JAN 28 1921, 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1921, to Jan 28, 1921, that I last saw h alive on Jan 28, 1921, and that death occurred, on the date stated above, at 720 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) E. Wilbur Stewart, M. D.

1/28, 1921 (Address) Md. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	Jan 30 1921

20 UNDERTAKER ADDRESS John O. Mitchell 120 N. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Stuessy)

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50290

CERTIFICATE OF DEATH.

D. 50290

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: ? WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Samuel Stuessy Miami Florida Miami Fla.

(a) RESIDENCE. No. 305 North East 26th Terrace ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Augusta K Stuessy.

6 DATE OF BIRTH (month, day, and year) March 26 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER Rudolph Stuessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Caroline Coppf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant (Address) J. H. Hospital Records

15 Filed Robert P. Harrison, Registrar

JAN 28 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Jan 27, 1921, that I last saw h.~~is~~ alive on Jan 27, 1921, and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Shock following operation for removal of hypophyseal tumor and hemorrhage about base of brain (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Miami Fla.

Did an operation precede death? Yes Date of 1-26-21

Was there an autopsy? Yes

What test confirmed diagnosis? Finding of pneumococci (Signed) T. H. Thomas, M. D.

1-28 1921 (Address) Johns Hopkins Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Miami Fla. DATE OF BURIAL Jan 28 1921

20 UNDERTAKER Geo W Little ADDRESS 581 N Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50291 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50291

CERTIFICATE OF DEATH. 104

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Ostend Av ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lawyer

(a) RESIDENCE. No. 1121 Ostend St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Clifton A Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lizzie K. Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Clifton T. Sawyer
(Address) 1121 Ostend St.

15 Filed JAN 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 20, 1921, to Jany 27, 1921, that I last saw h.. alive on Jan 27, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Metastases
ovul
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Indigestible food
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Dean, M. D.

(Address) 122 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan. 29 1921

20 UNDERTAKER C. H. Dill ADDRESS 3[illegible] Fairmount Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite syncnym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro-Enteritis

Spec.—8-24-14—M. & T.—2000 Bks.

D.50292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50292

CERTIFICATE OF DEATH.

X 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Biddle St.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bedford Stokes

(Residence in Baltimore: No. 523 N. Biddle St.; ..... yrs., 1 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Colored	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1851 (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or estsblishment in which employed (or employer)..... Odd Jobs

9-BIRTHPLACE, (State or Country), N C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adolphus Stokes

(Address) 523 N. Biddle St

15-

Filed ..... 191.....

JAN 28 1921

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Jan 28 1921, that I saw h-- alive on Jan 27 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chr. Cardio-Renal

Insufficiency

(Duration) 11 yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1-28-1921. (Address) 739 Gorsuch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Ruffin N. C.

19-PLACE OF BURIAL OR REMOVAL, Ruffin N C — DATE OF BURIAL, Jan 28, 1921

20-UNDERTAKER, Edmund Townsley — ADDRESS, 578 Biddle

Spec.—8-24-14—M. & T.—2000 Bks.

D.50293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1915 Walbrook Ave. WARD) 15

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Saml. Walker

(Residence in Baltimore: No. 1915 Walbrook Ave St.; about 2 mos. in Balto, about 4 yrs.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) 6 (Day), 1835 (Year)

7-AGE, 85 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Richard F. Walker

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Martha Henderson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest R. Walker

(Address) 1900 Walbrook Ave.

15- JAN 28 1921 Robert E. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 28th, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to Jan. 27th 1921, that I saw him alive on Jan. 27th 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Old age, with albuminuria, & calcareous lesion of heart

(Duration) 3 to 4 mos. X ds.

CONTRIBUTORY (Secondary) Acute congestion of lungs (Duration) X yrs. X mos. 2 ds.

(Signed) O. A. Hoffman M. D.

1-28-, 1921. (Address) 2700 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fair Fax VW — DATE OF BURIAL, Jan. 31, 1921

20-UNDERTAKER Wm Cook — ADDRESS North Ave

D50294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50294

CERTIFICATE OF DEATH.

168

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 831 Hamilton Terrace ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Mitchell

(Residence in Baltimore: No. 831 Hamilton Terrace St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH. about 1880
..... (Month) ..... (Day) ..... (Year)

7-AGE, about 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... nurse (home)
(b) General nature of industry, business, or establishment in which employed (or employer)..... 046

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Chalk

(Address) 831 Hamilton Terrace

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

JAN 28 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 28, 1921
..... (Month) ..... (Day) ..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Asphyxiation by illuminating gas. (accidental) 2 hrs.
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. D. Hennessy M. D.
(Coroner.)
Jan. 28, 1921 (Address) 1802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem

DATE OF BURIAL, Jan. 29, 1921

20-UNDERTAKER Geo. J. Smith

ADDRESS 1000 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50295

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5712 Bellona ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Thomas Norris

(a) RESIDENCE. No. 5712 Bellona ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Martha E. Norris

6 DATE OF BIRTH (month, day, and year) July-12-1835

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Gen Merchandise

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER Wm Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Wm S. Norris
(Address) 5712 Bellona Ad

15 Filed JAN 28 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 1906, 19..., to Jan. 28, 1921, that I last saw him alive on Jan. 27, 1921, and that death occurred, on the date stated above, at 11 4 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. D. Owen, M. D.

1-28, 1921 (Address) 5600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cem.	Jan 31 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

D.50296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50296

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Northwestern Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mildred Price

(a) RESIDENCE. No. 3004 Northwestern Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Edwin L Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Ruth Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Edwin Price
(Address) 3004 Northwestern Ave

15 Filed JAN 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1921, to January 28, 1921, that I last saw her alive on January 28, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None but physical signs

(Signed) Bertha E. Tapman M. D.

Jan 28 1921 (Address) 2733 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bal Wms Cem	Jan 31 1921
20 UNDERTAKER	ADDRESS
Wm Cook	N & G Mts.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50297 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50297

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 204 N. Monroe ST.: 70 WARD)

2-FULL NAME Mrs. Laura V. Marks

(a) RESIDENCE. NO. 204 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ✓ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo. W. Marks.

6 DATE OF BIRTH (month, day, and year) Febry 23-1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Hanover. Penna.

PARENTS

10 NAME OF FATHER Horatio Emmert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Susan B. Gitt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant George W. Marks (Address) 204 N. Monroe St.

15 Filed ... Robert P. Harrison Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1920, to January 27, 1921, that I last saw h.. alive on January 14, 1921, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Staphylitis Chronic
(duration) 5 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Valvular Heart disease
(Mitral valve) (duration) ✓ yrs. 5 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Urinary Examination

(Signed) George B. Shannon, M. D.

1/27 1921 (Address) 700 Fulton Ave West

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 31- 1921
20 UNDERTAKER	ADDRESS
William Cook	502 S. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Kindervater)

D.50298 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1939 n Patts Pk St. 8 WARD)

REGISTERED No. C 157

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Kindvater.

(Residence in Baltimore: No. 1939 n Patts Pk St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 2 (Day), 1836 (Year)

7-AGE, 84 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Kindervarter

(Address) 1617 Linden ave

15-

Filed JAN 28 1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) H. Gilden (Coroner.) M. D.

1-28-21, (Address) Fairfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem DATE OF BURIAL, Jan 29 1921

20-UNDERTAKER Wm Cook ADDRESS 502 E North ave

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50299

D. 50299 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland Genral Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia L Bowen

(a) RESIDENCE. No. 1714 Mosher ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, ~~Married~~, Widowed. ~~or Divorced (write the word)~~ Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Bernard V. Bowen

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md

PARENTS

10 NAME OF FATHER Geo Witman

11 BIRTHPLACE OF FATHER (city or town) Carroll Co (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Griffith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant, (Address) Miss Etta Boyer 1714 Mosher st

15 Filed JAN 28 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1921, to Jan 28, 1921, that I last saw her alive on Jan 28, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Chrome Myocarditis & Arterio Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. Wilbur Stewart, M. D.

1/28. 1921 (Address) Md. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Bridge Carroll Co Md — DATE OF BURIAL: Jan 31 21

20 UNDERTAKER: Bartlam & Yost — ADDRESS: 1729 W Lafayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No haemorrhage

Spec.—6-9-15—H. P. Co.—1000 Bks.

D.50300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50300

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn M. Spielman,

(a) RESIDENCE. NO. 2130 Madison Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Spielman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Flora Gray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant W. E. Tickner
(Address) Woodlawn Md

15 Filed JAN 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Jan. 28, 1921, that I last saw her alive on January 28, 1921, and that death occurred, on the date stated above, at 2 50 Pm.

The CAUSE OF DEATH* was as follows:

Appendicitis

from history (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 27, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) Rud Richardson, M. D.

, 19 (Address) Md. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Jan 30 1921
20 UNDERTAKER	ADDRESS
W. E. Tickner	Woodlawn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50301

CERTIFICATE OF DEATH.

64 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3350 Dilman Ter ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Letitia Cruett

(a) RESIDENCE. NO. 3350 Dilman Ter ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roland Cruett

6 DATE OF BIRTH (month, day, and year) Aug 9 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stand do

(b) General nature of industry, business, or establishment in which employed (or employer) Drug.

(c) Name of employer Sharp & Dohme

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Brittain

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Lavinia Rubens

13 BIRTHPLACE OF MOTHER (city or town) Phila.

(State or country) Pa

11 Informant Mr C. M. Johnson

(Address) 3350 Dilman Terrace

15 Filed Robert F. Harrison

Registrar

JAN 28 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1921, to Jan 26 1921, that I last saw h[illegible] alive on Jan 26 1921, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Boyer, M. D.

(Address) 1534 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jan 29 1921

20 UNDERTAKER Wm J Tickner & Sons North & Pa ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50302 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50302

8-09

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Rutland Ave ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Scruggs

(a) RESIDENCE. NO. 904 Rutland Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Scruggs

11 BIRTHPLACE OF FATHER (city or town) Albemarle (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Watson

13 BIRTHPLACE OF MOTHER (city or town) Windsor (State or country) Va

14 Informant Daniel Scruggs (Address) 904 Rutland Ave

15 Filed JAN 29 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1921, to Jan. 28, 1921, that I last saw h.. alive on Jan 28, 1921, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ..... yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Balto - Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 29 1921
20 UNDERTAKER	ADDRESS
Jnrs R A Elliott	1725 Ashland Ave

THIS IS A PERMANENT RECORD AND MUST BE FILLED OUT WITH UNFADING INK—Typewriter ribbon will not do. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50303 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 120 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Richardson

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed JAN 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1920, to January 27. 1921, that I last saw h im alive on January 27. , 1921, and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis
(No cerebral hemorrhage)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) V B Hoffman M. D.

1/27/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 31. 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50304

CERTIFICATE OF DEATH.

91-036

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3608 Eastern Ave ST.: 76 WARD)

2-FULL NAME Francis H. Albers

(a) RESIDENCE. NO. 3608 Eastern Ave ST., 76 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14-1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Walter Albers.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Walter Albers.
(Address) 3608 Eastern Ave.

15 Filed Robert P. Harrison, Registrar

JAN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1920, to Jan. 27, 1921, that I last saw him alive on Jan. 27, 1921, and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes. - Diabetes

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm. H. Knabe, M. D.

(Address) 3608 Hoch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Jan 29th 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50305

91-089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 604 N Madeira ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice L Berry

(Residence in Baltimore: No. 604 N Madeira St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	

6-DATE OF BIRTH, August 3 (Month) 1920 (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 5 mos. 25 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... poo

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Abraham Berry

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Georgia Harris

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A Berry

(Address) 604 N Madeira St

15-

Filed ..... 1921 Robert P. Harrison, Registrar.

JAN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1921, to Jan 28 1921, that I saw h— alive on Jan 28 1921, and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Joseph L Greenberg M. D.

Jan 28, 1921 (Address) 1 Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Asbury Cem	Jan 30th, 1921
20-UNDERTAKER	**ADDRESS**
Harry A Kolsky	1725 Orleans St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.50306 HEALTH DEPARTMENT--CITY OF BALTIMORE D.50306

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1388 N. North ave ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Behrend

(Residence in Baltimore: No. 1388 N. North ave St.: 68 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)

6-DATE OF BIRTH: March 19, 1853 (Month) (Day) (Year)

7-AGE: 67 yrs. 10 mos. 29 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Kapel Cohn

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Hannah Behrend

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B Behrend

(Address) 1388 N North ave

15

Filed JAN 29 1921, 191 ...

Robert P. Harrison,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 29 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to Jan 28, 1921, that I saw h-e alive on Jan 28, 1920, and that death occurred, on the date stated above, at 6.30 a(m).

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ... yrs. 3 mos. ... ds

Contributory (SECONDARY) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Asa Pollack M. D.

Jan 29, 1921 (Address) Asa Pollack

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Feb 1, 1921

20-UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Mad ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50307 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50307

CERTIFICATE OF DEATH.

8-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 N. Rose ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Munger

(a) RESIDENCE. NO. 6 N. Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5 / 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Munger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mamie Weidner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. John Munger
(Address) 6 N. Rose St.

15 Filed Robert P. Harrison Registrar

JAN 29 1921 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT AND ALL information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1921

17 I HEREBY CERTIFY, That I attended deceased from January 26, 1921, to Jany 28, 1921, that I last saw h[illegible] alive on Jany 28, 1921, and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isabel M. Athey, M. D.

, 19 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 29 1921

20 UNDERTAKER Jos. J. Merr ADDRESS 156 N. Luzerne ave.

Spec.—5-19-13—M. & T.—500 Bks.

D.50308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50308

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 744 Dolphin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Richardson

(Residence in Baltimore: No. 744 Dolphin St.; 2 yrs., — mos., — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb (Month) 12 (Day), 1868 (Year)

7-AGE.	If LESS than 1 day,
52 yrs. 11 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone
(b) General nature of industry, business, or establishment in which employed (or employer): Cutter

9-BIRTHPLACE, (State or Country), Somerset Co. Md

PARENTS.

10-NAME OF FATHER, Jessie W. Simpkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Sims

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. S. Richardson

(Address) 744 Dolphin St

15- Robert P. Harrison,

Registrar. JAN 20 1921, 191.....

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1920, to Jan 29th 1921, that I saw h.. alive on Jan 29th 1921, and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Simmons Harris M. D.

Jan 29, 1921 (Address) 744 Dolphin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Vernon Somerset Co Md	Jan 31, 1921

20-UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50309 ✓D.50309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Eutaw Place ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annia A Pond

(a) RESIDENCE. No. 2226 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John C Pond

6 DATE OF BIRTH (month, day, and year) November 21st 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Pond

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Mary Russell

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant H S. Thompson
(Address) 2226 Eutaw Place

15 Filed JAN 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to Jan 1921, that I last saw her alive on Jan 27 1921, and that death occurred, on the date stated above, at 1.25 A.M.

The CAUSE OF DEATH* was as follows:

chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia & myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

1-29 1921 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 31st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50310

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1240 N. Broadway St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Edwards

(a) RESIDENCE. No. 1240 N Broadway St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William H Edwards

6 DATE OF BIRTH (month, day, and year) Sept 22, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berryville Va

PARENTS

10 NAME OF FATHER Joseph King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa

12 MAIDEN NAME OF MOTHER Catherine Le Cron

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant E K Edwards Sr

(Address) 1240 N. Broadway

15 Filed JAN 29 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 21, to Jan 27th, 19 21, that I last saw her alive on Jan 27th, 19 21, and that death occurred, on the date stated above, at 3.09 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. B. Schwatka M. D.

, 19 (Address) 822 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 29th 1921
20 UNDERTAKER	ADDRESS
George S Schilling & Sons	1126 E Monument st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 (a) Cerebral Haemorrhage

(b) Old age

Spec.—8-24-14—M. & T.—2000 Blks.

D 50311 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 50311

D 2 Lloyd
2232 Eutaw Pl

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 120

CITY OF BALTIMORE: (No. 116 Virginia Av ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Shelley

(Residence in Baltimore: ,No. 116 Virginia St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Veterinarian
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. John Shelley

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bessie Linard

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Shelley

(Address) 116 Virginia Av

15- Robert P. Harrison, Registrar.

JAN 29 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Jan 29 1921, that I saw him alive on Jan 29 1921, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) O S Lloyd M. D.

Jan 29, 1921. (Address) 2232 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Feb 1, 1921

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 W North Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 2079

CITY OF BALTIMORE: (No. 2115 W. Mulberry St. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Elizabeth Steinhauer

(a) RESIDENCE. No. 2115 W. Mulberry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Steinhauer

6 DATE OF BIRTH (month, day, and year) March 16"1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lawrence W. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Elizabeth Allen
(Address) 2115 W. Mulberry St.

15 Filed JAN 29 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28" 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1921, to Jan 28, 1921, that I last saw her alive on Jan 27, 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation (Cardiac)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Herbert E. Block, M. D.

19 (Address) 1014 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan. 31 1921

20 UNDERTAKER Joseph B. Cooke ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50313

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gmonal Hosp. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Brandt Terry

(a) RESIDENCE. No. 514 Rosehill Terrace ST., WARD Buffalo N.Y.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John C. Terry.

6 DATE OF BIRTH (month, day, and year) May 10 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 837

(b) General nature of industry, business, or establishment in which employed (or employer): at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Buffalo New York

PARENTS

10 NAME OF FATHER Charles Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER Kate Hartmetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.

14 Informant: John C. Terry

(Address) 514 Rosehill Terrace

15 Filed . 19 Robert F. Harrison, Registrar

JAN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from December 28 1920, to Jan 27, 1921, that I last saw h[illegible] alive on Jan. 27, 1921, and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Le Gendre Dugan. M. D.

1/27 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 31 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Balto St

...should be stated EXACTLY. ...PHYSICIANS should state ...it may be properly classified. Exact statement of OCCUPA... ...on back of certificates.

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50314

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 4235 Euclid Ave. ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. S. Eyerly

(a) RESIDENCE. No. 4235 Euclid Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria A. Eyerly

6 DATE OF BIRTH (month, day, and year) Jan. 30th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Trainman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Eyerly

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Robert E. Cooney
(Address) 4235 Euclid Ave.

15 Filed 19 Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Jan 26, 1921, that I last saw him alive on Jan 26, 1921, and that death occurred, on the date stated above, at 5 45 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-29-1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 29 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHY... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex... of OCCUPATION is very important. See instructions on back of certificates.

D.50315 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1371 Frederick Ave ST.; 28 WARD) 175-001 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lee Blankner

(Residence in Baltimore: No. 3330 Stoppard St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, April 11, 1914
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
6 yrs. 9 mos. 16 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John M Blankner

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Maud Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M Blankner

(Address) 3330 Stoppard St

15- Robert P. Harrison,
Registrar.
JAN 29 1921 Burial Permit Clerk.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Chest & abdomen
Auto truck passing over
Body accident sudden
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration) 1 yrs. mos. ds.

(Signed) James M Burton M. D.
(Coroner.)
Jan 28, 1921 (Address) 700 Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Jan. 31, 1921

20-UNDERTAKER Joseph D. Cook ADDRESS 1003 W. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

D.50316 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 668 Hanover St ST. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Lynn

(Residence in Baltimore: No. 668 Hanover St)

St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Don't Know (Month) (Day) (Year)

7-AGE 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 670

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Perry Lynn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, A. Todd

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Millings

(Address) 668 Hanover St

15- JAN 29 1921

(Filed) ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or inquiry.~~) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or inquiry.~~) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know any

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Gorsuch M. D. (Coroner.)

1-27, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Jan 29, 1921

20-UNDERTAKER Samuel T Hemsley

ADDRESS 578 W Baltimore

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50317 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hall

(a) RESIDENCE. No. 103 N. Hughes st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Joseph Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Josephine Custus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records M.T.H.

15 Filed . 19 JAN 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1921, to Jan. 25, 1921, that I last saw him alive on Jan. 25, 1921, and that death occurred, on the date stated above, at 10.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. Faigley, M. D.

1-28-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JAN 29 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

Par. Wm. E. WOODALL.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Engineers and OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50318 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50318

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 827 Willow ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Lowry

(Residence in Baltimore: No. 827 Willow St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
F	W	Single

6-DATE OF BIRTH, 1 (Month) – 28 (Day), 1921. (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 7 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Lowry

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Mary G Parrish

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. G. Lowry

(Address) 827 Eutaw St.

15- Filed JAN 29 1921, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-28 1921, to 1-28 1921, that I saw h— alive on 1-28 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature birth - 6 mo.

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs....mos....ds.

(Signed) Dr Bernard Wise M. D.

1-28, 1921 (Address) 914 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, JAN 29 1921

20-UNDERTAKER Commissioner Health, ADDRESS

Per. Wm. E. WOODALL.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50319 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50319

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 McPhail ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Riehl

(a) RESIDENCE. NO. 108 McPhail ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa E. Riehl

6 DATE OF BIRTH (month, day, and year) Jan 25th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chas. Ketis Kemety

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Geo. Riehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md

12 MAIDEN NAME OF MOTHER Mary Riehl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md

14 Informant Theresa E. Riehl

(Address) 108 McPhail St

15 Filed JAN 29 1921 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1920, to Jan 28, 1921, that I last saw him alive on Jan 27, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chron. Tbc. Laryngitis

Unknown (duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Chas. C. Conner, M. D.

1/29, 1921 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 1st 1921

20 UNDERTAKER F. D. Hippert ADDRESS 223 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day or an hour, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact street address or location should be given. NAMES of parents should be stated EXACTLY. If LESS than a day or an hour, it may be properly classified. Exact street address or location should be given. NAMES of parents should be stated EXACTLY. If LESS than a day or an hour, CAUSE OF DEATH is very important. See instructions on back of certificates. OCCUPATION should state of OCCUPATION.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Marsh)

D.50320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50320

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.; 9 WARD)

2-FULL NAME Master Samuel Marsh

(a) RESIDENCE. NO. 1712 Carroll Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. H. Marsh.

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Simpson

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant George H. Marsh
(Address) 712 Carroll Ave.

15 Filed Robert P. Harrison, Registrar

JAN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28 1921

17

I HEREBY CERTIFY, That I attended deceased from 1/26, 1921, to 1/28, 1921, that I last saw h- alive on 1/28, 1921, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia - Primary

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. L. Rudy M. D.

1/29, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 31 1921

20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut ave

mation should be carefully supplied. AGE should be stated EXACTLY. PLACE OF BIRTH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50321 HEALTH DEPARTMENT—CITY OF BALTIMORE D50321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1014 Russell Terrace St.: 16 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lee

(Residence in Baltimore: No. 1014 Russell Terrace St.; 62 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	widower

6-DATE OF BIRTH, Unknown, 1859.
(Month) (Day) (Year)

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer (Quarry)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella Buckner

(Address) 1711 Baker St

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan, 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Kennissy M. D.
(Coroner.)

Jan 29, 1921 (Address) 780 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Calvert	Jan. 29. 1921

20-UNDERTAKER Edw. Ringgold ADDRESS 1463 Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 Hanford Rd ST.: 77 50 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dr. Vansant

(a) RESIDENCE. No. 27 Hanford Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. May Vansant

6 DATE OF BIRTH (month, day, and year) June 25th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bel Air Maryland

PARENTS

10 NAME OF FATHER Thomas N. Vansant

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Hunter

13 BIRTHPLACE OF MOTHER (city or town) Bel Air, (State or country) Maryland

14 Informant A. May Vansant (Address) Hamilton Md.

15 Filed ....., 19.....

JAN 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19[illegible], to Jan 25, 1921, that I last saw h[illegible] alive on Jan 25, 1921, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? I

(Signed) Geo. L. Long, M. D.

19 (Address) 27 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edgewood Cemetery	Jan. 31 19 21
20 UNDERTAKER	ADDRESS
Robt. Greenwood	Aberdeen

D.50323

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.50323

CERTIFICATE OF DEATH

152

REGISTERED NO. C.....

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY ~~... PHYSICIANS should~~ state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ~~... CONDITION~~ is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 N. Fotherwood Ave ST.; 7 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Coleman

(Residence in Baltimore: No. 718 N. Fotherwood St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6-DATE OF BIRTH: January (Month) 23 (Day), 1921 (Year)

7-AGE: ..... yrs. ..... mos. ✓ ds.

If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: John Coleman

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Hillman

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Coleman

(Address) 718 N Fotherwood

15 Robert P. Harrison, 191 Burial Permit Clerk, REGISTRAR

JAN 29 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 23, 1921, to January 28 1921, that I saw h[illegible] alive on January 28, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Immediate Cause: Inanition

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY): Weak Forceps Delivery

Bilateral Brain Injury

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Talen M. D.

1-28, 1921. (Address) 508 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pikesville Dale Lawn Pike

DATE OF BURIAL: January 29, 1921

20-UNDERTAKER: Robt. Johnson

ADDRESS: 1424 Bway

Spec.—8-24-14—M. & T.—2000 Blks.

D.50324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50324

CERTIFICATE OF DEATH.

30

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 N Milton Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Avelyn Barbara Frater

(Residence in Baltimore: No. 701 A. Glover St St.; yrs., 2 mos. ds.)

X

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
yrs. 11 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Harry A. Frater

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mary E. Simmons

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry E Frater

(Address) 701 A. Glover St

15-

Filed JAN 29 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 - 1921, to Jan 28 1921, that I saw her alive on Jan 28 1921, and that death occurred, on the date stated above, at 11.55 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wheeler Hickey M. D.

Jan. 29, 1921. (Address) Maple Ave & Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dan Lamplett Sec — DATE OF BURIAL, Jan 31, 1921.

20-UNDERTAKER Robt Skinner — ADDRESS 1442 N Bway

D 50325 HEALTH DEPARTMENT--CITY OF BALTIMORE D.50325

CERTIFICATE OF DEATH

1-PLACE OF DEATH — 186 — REGISTERED NO. C.....

CITY OF BALTIMORE (No. Balto City Jail St.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Perry Williams

(Residence in Baltimore: No. ..... St.: ..... yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: Col

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ~~Jan 28, 1921~~ (Month) (Day) (Year)

7-AGE: 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Geo. H. Perry

11-BIRTHPLACE OF FATHER (State or country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James H Dennis

(Address) 1303 Forrestman St

15

JAN 29 1921

Robert P. Harrison,
REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan 28, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 28 1921, that I saw him alive on Jan 28, 1921, and that death occurred, on the date stated above, at 9.05 a m.

THE CAUSE OF DEATH* was as follows:

Dislocation of Cervical vertebrae.
Executed at Balto. City Jail.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY): Hanging by neck

(Duration) 10 minutes yrs. ..... mos. ..... ds.

(Signed) H. J. Powers M. D.

Jan 29, 1921 (Address) 921 N. Ross St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 31, 1921

20-UNDERTAKER: James H Dennis — ADDRESS: 1303 Forrestman St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50326

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 44 Mulfield Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzette Cooper Lucas.

(a) RESIDENCE. No. 44 Mulfield Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frank Knox Lucas.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Jacob Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Patience Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) 117 Garrison Lane

15 Filed ..... 19 Robert P. Harrison, Registrar

JAN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1919, to Jan 26, 1921, that I last saw h.. alive on Jan 26, 1921, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Valvular Insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Adler M. D.

1/27/21 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 29 1921
20 UNDERTAKER	ADDRESS
Geo. V. Schwab & Bro	2101 Eutaw Pl

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50327 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50327

CERTIFICATE OF DEATH. 89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Quinn

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 1846

7 AGE: Years 75 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Sister Florence Preston & Valley Sts.

JAN 29 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19.., to ....., 19....,

that I last saw her alive on January 27, 1921,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Debility of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warren, M. D.

(Address) 1132 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Mary's Govans Jan 31 1921

20 UNDERTAKER — ADDRESS

H. C. Wiedefeld 914 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50328

CERTIFICATE OF DEATH.

X 39

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1613 N. Wolfe St ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bauman

(a) RESIDENCE. No. 1415 N. Capital St Wash. D. C. WARD. ... to D.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 21 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis G Bauman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Bushar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Bushar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Louis G Bauman

(Address) 1415 N Capitol St Washington D.C.

15 JAN 30 1921 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 10 1921, to January 29 1921, that I last saw her alive on January 29 1921, and that death occurred, on the date stated above, at 1148 A.m.

The CAUSE OF DEATH* was as follows:

Blood Poision +
Carcinoma of Mouth +
Throat

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Carcinoma of Mouth + Throat (duration) 1 yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Wash. D. C

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. W Kennard, M. D.

1-29-21 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Md	26 Jan 1921
20 UNDERTAKER	ADDRESS
J C Mitchell	1201 24 Fayette St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

050329 HEALTH DEPARTMENT—CITY OF BALTIMORE 050329

CERTIFICATE OF DEATH.

REGISTERED NO. C 379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 S. Exeter ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Pumpeansky

(Residence in Baltimore: No. 115 S. Exeter St.: 35 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 78 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Henry Pumpeansky

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Pumpeansky

(Address) 919 W Fayette St

15- JAN 30 1921 Filed ..... 191.. ROBERT J KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Jan 26 1921, that I saw h— alive on Jan 28 1921, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Organic Dis of the Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr D. Wallenstein M. D.

Jan 28, 1921 (Address) ~~Est~~ 6 S. Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 115 S. Exeter st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Henry Pur — DATE OF BURIAL, Jan 30, 1921

20-UNDERTAKER Max Levinson — ADDRESS 1128 Balto st

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Loveless

HEALTH DEPARTMENT—CITY OF BALTIMORE

145575 D50330

CERTIFICATE OF DEATH.

X 122 D50330

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Loveless

(a) RESIDENCE. No. 119 West 21st St. City ST.. WARD. Memphis Tenn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Loveless

6 DATE OF BIRTH (month, day, and year) May 3-1880

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	20	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Aaron Loveless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Ida Nassins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Mrs. Jul Bruce (Address) 1119 W. Fayette St.

15 Filed JAN 30 1921 ROBERT E. LEAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 27, 1921, that I last saw h-sm alive on Jan 27, 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Phlegmonous Cystitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) pyelonephritis

(duration) yrs. 1? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 20, 21

Was there an autopsy? yes

What test confirmed diagnosis? pathological

(Signed) H. H. Lacey, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Memphis Tennessee	Jan. 31 1920
20 UNDERTAKER Joseph A Farrell	ADDRESS 2319 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Jeremiah Gordon

D50331 HEALTH DEPARTMENT—CITY OF BALTIMORE D50331

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 622 W. Saratoga St. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvina Gordon

(Residence in Baltimore: No. 622 W. Saratoga St. St. 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ... (Month) Dec. (Day) 1 (Year) .....

7-AGE, 71 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Porter (b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Joseph Gordon

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Louise McGibbons

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Wyatt

(Address) 622 W. Saratoga St

15- FILED JAN 30 1921 ROBERT B. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Jan. (Day) 27, (Year) 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H K Tormey M. D. (Coroner.)

1-28, 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL, Jan 30 1921

20-UNDERTAKER: Brown & Freeland — ADDRESS 114 N Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Carman

D50332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50332

CERTIFICATE OF DEATH.

8 120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Carman

(Residence in Baltimore: No. 1609 N. Broadway St.; 86 yrs., 9 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, April 4, 1834 (Month) (Day) (Year)

7-AGE, 86 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Donald Mac Lain

11-BIRTHPLACE OF FATHER (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Margaret Morrison

13-BIRTHPLACE OF MOTHER (State or Country): Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J Horner

(Address) 1609 N. Broadway

15- JAN 30 1921 ROBERT E KRAUTER

Filed....., 191... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 28 1921, that I saw her alive on Jan 28 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) John T Avery M. D.

Jan 30, 1921 (Address) 1603 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 31, 1921

20-UNDERTAKER Henry Lutz — ADDRESS 1007 N. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

050333 HEALTH DEPARTMENT—CITY OF BALTIMORE 050333

CERTIFICATE OF DEATH.

REGISTERED No. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp. St.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonina Fialkowska

(Residence in Baltimore: No. 107 Locust St.)

30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Felix Ordakowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Ludwika Brojek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoni Fialkowski

(Address) 107 Locust St

15- FILED JAN 30 1921 ROBERT B. KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction bowels
Dont know cause
Sunday (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Assistants
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 29, 1921 (Address) 1059 Key

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 dy yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross D.H.C. DATE OF BURIAL, Jan 31, 1921

20-UNDERTAKER Wm. Fialkowski ADDRESS Cautery

See affidavit Max Yudkson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50334 — D50334 — 53

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Calvin Av., ST.: 17 WARD)

2-FULL NAME Max Yudelson

(a) RESIDENCE. No. 431 Calvin Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fanny

6 DATE OF BIRTH (month, day, and year) — 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor (Merchant)

(b) General nature of industry, business, or establishment in which employed (or employer) 090

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Selman Yudelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Selma —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 141 E. Baltimore St

15 Filed JAN 30 1921 ROBERT B. CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Jan 29, 1921, that I last saw h.. alive on Jan 29, 1921, and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Pancreatitis chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Meyer Ephraim, M. D.

, 19 (Address) 1904 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 1/30 1921

20 UNDERTAKER Jack Lewis — ADDRESS 141 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md., Feb. 3, 1921.

I do hereby make oath that the name of deceased given on Baltimore City Health Department Certificate No. D-50334 as Max Yudeson is not correct and that same should be Max Yudelson; also that the age given is incorrect. Same is given as 49 years and it should be 47 years.

Jack Levis

Subscribed and sworn to before me this 3d day of February,

Rich Gatto

Spec. 6-9-19 H. P. Co.—1000 Blks.

D50335 HEALTH DEPARTMENT—CITY OF BALTIMORE D50335

CERTIFICATE OF DEATH. 29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 E. Fayette St. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Sachs

(a) RESIDENCE. NO. 2319 E. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida Sachs

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 080

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS'

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Freida Sachs

(Address) 2319 E Fayette St

15 Filed JAN 30 1921 ROBERT B. CHANLER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1918 19 .. to Jan. 29 19 21, that I last saw him alive on Jan. 2 19 21, and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Tubular disease

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph D. Talkin M. D.

1/29 1921 (Address) 221 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	1/30 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 Eldon St

A. B. WRITE PLAINLY with pen and ink and use unfading ink. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050336

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050336

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Hollins ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Goldberg

(a) RESIDENCE. No. 1018 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Goldberg

6 DATE OF BIRTH (month, day, and year) — 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore St

15 Filed JAN 30 1921 ROBERT E KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/27, 19..., to 1/29/, 1921, that I last saw h—alive on 1/29/, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) History yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Bernard J Levy, M. D.

1/30, 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Sinai Cemetery	1/30/21 19

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050337 HEALTH DEPARTMENT—CITY OF BALTIMORE 050337

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 1504 N. Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Geminine Lafferty

(a) RESIDENCE. No. 1504 N. Gay ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred all life save 6 months How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Lafferty

6 DATE OF BIRTH (month, day, and year) Apr 6 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 000

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Harlem N. Y.
(State or country)

PARENTS

10 NAME OF FATHER Daniel Connell

11 BIRTHPLACE OF FATHER (city or town) Harlem
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Margaret Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Samuel E Lafferty
(Address) 2124 Eutaw St

15 Filed JAN 30 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1- 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 29, 1921, that I last saw h.. alive on Jan 29, 1921, and that death occurred, on the date stated above, at 6-A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feby 1 19 21
20 UNDERTAKER	ADDRESS
J. M. Cook	502 E Eutaw

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050338 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050338

CERTIFICATE OF DEATH.

HO

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 N. Gay ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Reeves

(a) RESIDENCE. No. 1508 N. Gay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Robert C. Reeves.

6 DATE OF BIRTH (month, day, and year) Dec. 25 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbott Co. Md.

PARENTS

10 NAME OF FATHER Wm. A. Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co. Md

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbott Co Md

14 Informant Edna A. Burns
(Address) 1508 N. Gay Street.

15 Filed JAN 30 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920, to Jan. 29, 1921, that I last saw h.. alive on Jan. 29, 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. E. Magness, M. D.

Jan 29, 1921 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb. 1 1921

20 UNDERTAKER William Cook

ADDRESS 502 E. North Ave.

INFORMATION should be carefully supplied. Age, should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50339 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50339

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 621 Barre St ST.: W WARD)

2-FULL NAME Mary S. Webb.

(a) RESIDENCE. NO. 621 W. Barre St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred many years How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Motherhead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Eleanor Perkins
(Address) 3048 Brighton St.

15 Filed JAN 30 1921 19 ROBERT A BRAUTLE Registrar
Burial Permit 01078

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1920 to Jan. 28 1921.

that I last saw her alive on Jan. 27. 1921.

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of bladder.

(duration) yrs. 7 mos. ds.

(Secondary) Epithelioma. Carcinoma of bladder

(duration) yrs. mos. ds.

18 Where was disease contracted? Not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? — No —

What test confirmed diagnosis? Clinical

(Signed) M. G. Freiman M. D.

1-28 1921 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kinsale - Va	Jan 31 1921
20 UNDERTAKER Wm. Cook	ADDRESS 532 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Meginnis

D50340 HEALTH DEPARTMENT—CITY OF BALTIMORE D50340

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1930 Lanvale Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Estelle Meginnis

(a) RESIDENCE. No. 1930 Lanvale Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15 JAN 30 1921 ROBERT A. LAZZELL Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1920

17

I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19 ...,

that I last saw h... alive on ....., 19 ...,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cancer of left Breast

.....(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) .....

.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 31/20
20 UNDERTAKER	ADDRESS
Gw J Smith	1005 N Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50341

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 38 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter J Fallon

(a) RESIDENCE. No. 1 Montgomery St Jersey City N.J. St., Ward. Jersey City N.J.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? 28 yrs. 1 mos. 1 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
28	0	0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ins. Solicitor M1

(b) General nature of industry, business, or establishment in which employed (or employer) Ins. Work

(c) Name of employer Not Given

9 BIRTHPLACE (city or town) (State or country) Hoboken N.J.

PARENTS

10 NAME OF FATHER John J. Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Adelia Zuppinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hoboken N.J.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 Filed JAN 30 1921 ROBERT B. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1918, to Jan 30, 1921, that I last saw him alive on Jan 29, 1921, and that death occurred, on the date stated above, at 7-30 a m.

The CAUSE OF DEATH* was as follows:

Fibroid Phthisis

abt (duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Depressive

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Hoboken N.J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jersey City N.J.	Jan 30 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 23 WARD)

REGISTERED NO. 172

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Bachman

(a) RESIDENCE. No. 13 Poultney St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1840

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker 088

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Bachman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records, (Address) New City Hospital.

15 FILED JAN 30 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1920, to January 29, 1921, that I last saw him alive on January 28, 1921, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of right femur. Cerebral

(duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? not as yet.

What test confirmed diagnosis? X ray & exam.

(Signed) F. A. Holden, M. D.

1/29/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	1-31 1921
20 UNDERTAKER	ADDRESS
E and B Hearle	115 E Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Huffman

D50343 ✓ D50343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dock Huffman

(a) RESIDENCE. NO. Ronda, N C ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Huffman

6 DATE OF BIRTH (month, day, and year) June 3 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Eli Huffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sallie Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Record

(Address) J H H

15 Filed JAN 30 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to Jan 29, 1921, that I last saw h... alive on Jan 27, 1921, and that death occurred, on the date stated above, at 4 35 a m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Streptococcus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 17 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) H. A. Kelly, M. D.

, 19 (Address) Johns Hopkin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ronda North Carolina	1/30 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Joseph Blaszczyk.

Spec.—8-24-14—M. & T.—2000 Bks. D50344

HEALTH DEPARTMENT—CITY OF BALTIMORE D50344

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 431 S. Dallas ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Blaszczyk

(Residence in Baltimore: No. 431 S. Dallas St.; 8 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, Feb (Month) ..... (Day) ....., 1882 (Year)

7-AGE,	If LESS than 1 day,
39 yrs. 11 mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Poland (Kalisz)

PARENTS.

10-NAME OF FATHER, Ignatius Blaszczyk

11-BIRTHPLACE OF FATHER (State or Country), Poland (Kalisz)

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Kalisz Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Blaszczyk

(Address) 431 S. Dallas

15- JAN 30 1921 Filed ....., 191.. ROBERT F. KRAUSE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1920 to Jan 28 1921, that I saw h.. alive on Jan 28 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Cardiac Weakness

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Thos. L. Watkins M. D.

Jan. 29, 1921 (Address) 1015 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus,	Jany. 31, 1921
20-UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L050345 — HEALTH DEPARTMENT — CITY OF BALTIMORE — L 50345

CERTIFICATE OF DEATH

REGISTERED No. C 50

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Orkney Road St.; 29 Graus WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Funk

(Residence in Baltimore: No. 506 Orkney Road St.; 62 yrs. 10 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6-DATE OF BIRTH: Mar. (Month) 12 (Day) 1858 (Year)

7-AGE: 62 yrs. 10 mos. 17 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Wm Funk

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arnold Funk

(Address) 506 Orkney Rd

15- JAN 30 1921 Filed ..... 191 ROBERT E CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 29 (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from April, 1919, to, Jany. 28 1921, that I saw h.im. alive on Jany. 28, 1921, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 3 yrs. — mos. — ds.

Contributory (SECONDARY) Chronic interstitial nephritis

(Duration) 2 yrs. — mos. — ds.

(Signed), C. D. Breeden M. D.

Jany 29 1921 [Address] 3949 Fremont Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL: Feb 1 1921

20-UNDERTAKER: Wm Fuchs — ADDRESS: North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(See affidavit over) D 50346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Southern Hospital St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Ellen Yingling

(Residence in ~~Baltimore~~: No. Asbestos Md St.; ..... yrs., ... mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	wh	Married

6-DATE OF BIRTH, June (Month) ..... (Day), 1864 (Year)

7-AGE, 50. ~~59~~ yrs. 7 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country). Carroll Co Md

PARENTS.

10-NAME OF FATHER, William Ward

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co Md

12-MAIDEN NAME OF MOTHER Mary Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) MacKendree Yingling

(Address) Southern Hospital

15- JAN 30 1921 Filed..... 191.... ROBERT B. BRAUER Deputy Registrar.

2/2/1921 Geo. A. Grese

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 30 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1921, to Jan 30 1921, that I saw h[er] alive on Jan 29 1921, and that death occurred, on the date stated above, at 11 3/4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast and general Anasarca

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Obstruction

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alex Pallack M. D.

Jan 30, 1921 (Address) 1112 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 24 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Asbestos Carroll Co Md

19-PLACE OF BURIAL OR REMOVAL, Reisterstown M. E. Cem. | DATE OF BURIAL, 2/1....., 1921

20-UNDERTAKER J. Walter Davis | ADDRESS 3307 Paine St

SAVE THIS CERTIFICATE. CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baltimore, Md., Feb. 3, 1921.

oath
I do hereby make/that the age of deceased, Martha Ellen Yingling, given on Baltimore City Health Department Certificate D-50346, as 59 years and 7 months in incorrect; and that same should be 50 years and 7 months.

Flora Pallack
Physician.

Subscribed and sworn to before me this 3d day of February, 1921.

Reed Gaither

Spec.—6-9-19—H. P. Co.—1000 Bka.

D45839
D50347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50347

CERTIFICATE OF DEATH.

132

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Robinson

(a) RESIDENCE. No. 930 Argyle ave St. City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Milton Robinson

6 DATE OF BIRTH (month, day, and year) Aug 21 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Fell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant J. Hopkins Hospital Records
(Address)

15 Filed JAN 31 1921 ROBERT E. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Jan 27, 1921, that I last saw her alive on Jan 27, 1921, and that death occurred, on the date stated above, at 11:50 a m.

The CAUSE OF DEATH* was as follows:

Patient died on operating table cause not known. 6 puncture hypodermoclysis left scapular region. Pulse and respiration ceased 5 minutes before death. No anesthetic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myoma present for 2 years upon operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 27, 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

1/27 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Jan 31 1921
20 UNDERTAKER	ADDRESS
Samuel Hensley	878 N Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Over)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50348 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D50348

CERTIFICATE OF DEATH.

REGISTERED NO. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Dorsey

(a) RESIDENCE. NO. 623 Pitcher Street ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Leander Dorsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie Lumsden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J H Hospital Records
(Address)

15 Filed JAN 31 1921 ROBERT J KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 19 21, to Jan 28, 19 21,
that I last saw h[er] alive on Jan 28, 19 21,
and that death occurred, on the date stated above, at 3.45 a m.
The CAUSE OF DEATH* was as follows:
Tuberculous meningitis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Lumbar puncture
(Signed) W E Dawson, M. D.
Jan 28 1921 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 31 1921
20 UNDERTAKER	ADDRESS
Samuel Hensley	58 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50349 HEALTH DEPARTMENT—CITY OF BALTIMORE D50349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 21 St. Schroder ST. 18 WARD)

2-FULL NAME Lillian Reed

(Residence in Baltimore: No. 21 St Schroder St St.; yrs., mos. ds.)

REGISTERED No. C 1047

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colord	Single

6-DATE OF BIRTH, Jan (Month) 14 (Day), 1921 (Year)

7-AGE, yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bath City

PARENTS.

10-NAME OF FATHER, John Reed

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Holden

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Reed

(Address) 21 St Shroder

15- Filed JAN 31 1921, 191 ROBERT B. GRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said (Inquest, ~~autopsy or inquiry.~~) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Justus Enteritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Prematur birth

(Duration) yrs. mos. 14 ds.

(Signed) W. F. Forsyth M. D. (Coroner)

1-28, 1921 (Address) 117 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn St. DATE OF BURIAL, 1-31, 1921

20-UNDERTAKER Daniel L. Bruce & Son ADDRESS 1058 Montgomery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 2050350 — 40-691 2050350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Carroll

(a) RESIDENCE. No. 22 East Chase St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 840

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Maria Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address) J. H. H.

15 FILED JAN 31 1921 ROBERT B. BRUCE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 - 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 17 - 1921, to Jan 28, 1921, that I last saw h... alive on Jan 28, 1921, and that death occurred, on the date stated above, at / .. m.

The CAUSE OF DEATH* was as follows:

1 Carcinoma stomach primary

2 Broncho-pneumonia sudden

3 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Date of Jan 18 21

Was there an autopsy?

What test confirmed diagnosis? Gross microscopical examination of tumor

(Signed) J. H. Black, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct.	Jan. 31 1921
20 UNDERTAKER	ADDRESS
David L. Brown Son	10 Mt. Vernon Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50351

CERTIFICATE OF DEATH.

91-684

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 Lemon, ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Thos. Linkhard.

(a) RESIDENCE. NO. 931 Lemon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 26 ds. How long in U. S., If of foreign birth? yrs. 1 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 3. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 800

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thos. E. Linkhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newport News. Va

12 MAIDEN NAME OF MOTHER Pearl Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co. Md

14 Informant Thos. E. Linkhard
(Address) 931 Lemon.

15 Filed JAN 31 1921 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 25 1921, to Jan. 29 1921, that I last saw him alive on Jan 28 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

1/29. 1921 (Address) 638 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	1/31 1921
20 UNDERTAKER	ADDRESS
J. Fus McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

50352 HEALTH DEPARTMENT—CITY OF BALTIMORE 50352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 N. Baltimore St. 20th WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Meckel

(a) RESIDENCE. No. 2509 N. Baltimore St. 20th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Meckel

6 DATE OF BIRTH (month, day, and year) March 17 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 037

(b) General nature of industry, bosiness, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nancy M. Meckel (Address) 2509 N. Baltimore St

15 Filed JAN 31 1921, 19 ROBERT I. CRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to Jan 30, 1921, that I last saw h[illegible] alive on Jan 29, 1921, and that death occurred, on the date stated above, at 4.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Institial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? none

(Signed) Venus H. Cordes, M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 2 19 21

20 UNDERTAKER C. B. Kimport ADDRESS 223 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P Co.—1000 Blks.

Smufsky.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50353

1645748

D 50353

CERTIFICATE OF DEATH.

5 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Smufsky.

(a) RESIDENCE. No. 517 N. High St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married (-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Smufsky.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lela Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. H. Hospital records

15 Filed JAN 31 1921 ROBERT A. [illegible] Registrar

Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 30, 1921, that I last saw h[illegible] alive on Jan 30, 1921, and that death occurred, on the date stated above, at 5 12 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Uremia & Pulmonary Edema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood & Urinary Findings

(Signed) Henry M. Thomas Jr. M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	1/31 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50354 HEALTH DEPARTMENT—CITY OF BALTIMORE D50354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 N Payson St. 16 Ward)

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Luther Stutt

(a) RESIDENCE. No. 813 N Payson St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28/20

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, ...hrs. or ....min.: 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Philip Stutt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Blanche G Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Philip Stutt 813½ Payson St

15 Filed JAN 31 1921, 19.... ROBERT J. BRUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 19.21, to Jan 27, 19.21, that I last saw h.... alive on Jan 19, 19.21, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) .... yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) 0000

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Martin W Stutt, M. D.

, 19 (Address) 813 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Jan 31 1921

20 UNDERTAKER: J McCook — ADDRESS: 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50355 HEALTH DEPARTMENT—CITY OF BALTIMORE D50355

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1149 Mc Elderry ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Anderson

(a) RESIDENCE. No. 1149 Mc Elderry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Anderson

6 DATE OF BIRTH (month, day, and year) May-13-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Cole

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Keys

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ernest Cole
(Address) 504 N. Spring St.

15 Filed JAN 31 1921, 19 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-27, 1921, to 1-29, 1921, that I last saw her alive on 1-29, 1921, and that death occurred, on the date stated above, at 2.55 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam.

(Signed) Ralph J. Young, M. D.

19 (Address) 1416 Jefferson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	2-3 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50356 HEALTH DEPARTMENT—CITY OF BALTIMORE D50356

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 E. Fairmount Av 6 ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude F. Helfrich

(a) RESIDENCE NO. 1811 E. Fairmount Av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 4/1904

7 AGE: Years 16 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Helfrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John Helfrich 1811 Fairmount Ave

15 Filed JAN 31 1921 ROBERT P. LEAVELL Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/30/21

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 30, 1921, that I last saw h[illegible] alive on Jan 29, 1921, and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis over

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Phy Signed

What test confirmed diagnosis? C. C. Phy Findings

(Signed) J. C. [illegible], M. D.

(Address) 1437 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — DATE OF BURIAL: 2-3 1921

20 UNDERTAKER: Holleran Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Was a pt at N of M Hospital 6 mths. Imed Call pic an emergency.
B Jados

Patient treated at Hospt. for mitral stenosis & regurgitation.

050357 HEALTH DEPARTMENT—CITY OF BALTIMORE 050357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2405 Maryland Ave. WARD) REGISTERED No. C 279

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisa Voltzman

(Residence in Baltimore: No. 2405 Maryland Ave St. 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Nov (Month) 28th (Day) 1833 (Year)

7-AGE 87 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 0.0

9-BIRTHPLACE, (State or Country), Europe

PARENTS.

10-NAME OF FATHER, Frank Kemper

11-BIRTHPLACE OF FATHER (State or Country) Europe

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country) Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lillian Stryker

(Address) 2405 Maryland Ave

15- FILED JAN 31 1921 191.... ROBERT A KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Grossmann M. D. (Coroner.)

Jan 29, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, 2-2, 1921

20-UNDERTAKER William Cook ADDRESS 502 E Nat

Monday

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6-9-19—H. P. Co.—1000 Bks.

1050358 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hosp. REGISTERED NO. 92

CITY OF BALTIMORE: (No. 418 W. Lexington ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle M. Goulden

(a) RESIDENCE. No. 1709 Cole ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1st 1920

7 AGE — Years: 11 — Months: — — Days: 30 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. W. Goulden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Myrtle V Treadell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

11 Informant (Address): Myrtle M Goulden 1709 Cole St

15 Filed JAN 31 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1921, to 1-30, 1921, that I last saw her alive on Jan. 30, 1921, and that death occurred, on the date stated above, at 7.5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1709 Cole St.,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Sputum~~ clinical

(Signed) J. L. Payan all, M. D.

1-30, 1921 (Address) 418 W. Lexington St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 2-1st 1921

UNDERTAKER: Robert. Brooks & Son — ADDRESS: 17 S Calhoun St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner.* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—8-24-14—M. & T.—2000 Bks.

D50359 HEALTH DEPARTMENT—CITY OF BALTIMORE #D50359

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 N Carrollton ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie V. Murray

(Residence in Baltimore: No. 328 N Carrollton ave St.; 41 yrs., 6 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, Married, Widowed, or Divorced (Write the word.): Married

6-DATE OF BIRTH: Aug (Month) 15 (Day) 1879 (Year)

7-AGE: 41 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Baltimore city

PARENTS.

10-NAME OF FATHER: Danl. Tatum

11-BIRTHPLACE OF FATHER (State or Country): Baltimore city

12-MAIDEN NAME OF MOTHER: Mary Spetzler

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Danl. Tatum

(Address) 328 N Carrollton ave

15- ROBERT P. KRAUTH

Filed JAN 31 1921 191.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1919, to Jan 28 1921, that I saw h[illegible] alive on Jan 28 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(a) Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(b) Duration) yrs. mos. ds.

(Signed) R. L. Campbell M. D.

Jan 30, 1921 (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan 30 1921

20-UNDERTAKER Robert Brookseam ADDRESS CALHOUN HOLLINS ST

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50360 HEALTH DEPARTMENT—CITY OF BALTIMORE D50360

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Wisma Apts

CITY OF BALTIMORE: (No. Park Ave & Monument ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Clendenin

(a) RESIDENCE. NO. Park Ave & Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Rowan Clendenin

6 DATE OF BIRTH (month, day, and year) Oct 23 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	4	6	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Copper & Metal

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer Clendenin Bros.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Clendenin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Rowan Clendenin
(Address) Park Ave & Monument St

15 Filed JAN 31 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Jan 29, 1921, that I last saw him alive on Jan 29, 1921, and that death occurred, on the date stated above, at 11.05 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Can't say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No test used

(Signed) Geo L Fonerey M. D.

Jan 31st 1921 (Address) 1107 Lexington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2/1 1921

20 UNDERTAKER ADDRESS

Chas F. Evans & Son 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50361

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Rutland Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Monica Eugenia Chouplin

(a) RESIDENCE. No. 1001 Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 109

(b) General nature of industry, business, or establishment in which employed (or employer) Henry Tonetom

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Francis Chouplin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Blanch Marks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belair Md

14 Informant Loretta Chouplin
(Address) 1001 Rutland Ave.

15 Filed JAN 31 1921 16 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1920, to Jan 29, 1921, that I last saw her alive on Jan 29, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) N. L. Flanner, M. D.

Jan 31, 1921 (Address) 1301 N Pat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb 1st 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son, Funeral Directors & Embalmers.	811 N Colvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50362 HEALTH DEPARTMENT—CITY OF BALTIMORE D50362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 S. Payson ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ordery A. Dixon

(a) RESIDENCE. No. 337 S. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Elmer Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Annie E Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Mr. Elmer Dixon (Address) 337 S Payson St—

15 Filed JAN 31 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1921, to Jan 30, 1921, that I last saw her alive on Jan 30, 1921, and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Microscopic

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter A Cof, M. D.

1-31, 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Jan 31 1921

20 UNDERTAKER John J. Gowan & Son — ADDRESS 901 Hollins St—

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50363

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1416 W. Mulberry St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Hoffman Gommyer

(a) RESIDENCE. No. 1416 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. H. H. Gommyer

6 DATE OF BIRTH (month, day, and year) Aug 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady 067

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer Hochschild, Kohn & Co

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Isley

13 BIRTHPLACE OF MOTHER (city or town) Cecil
(State or country)

14 Informant G. H. H. Gommyer
(Address) 122 Mosher Ave

15 Filed JAN 31 1921 19 ROBERT A. CRAWFORD Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1920, to Jan. 26 21, that I last saw h. alive on Jan. 26 21, and that death occurred, on the date stated above, at 615 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 0 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) 0 yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home & Room

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Perfection

(Signed) H. H. Hamer, M. D.

, 19 (Address) 700 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 31 1921

20 UNDERTAKER Sam Weber & Son ADDRESS 2503 Druid Hill Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D50364 HEALTH DEPARTMENT—CITY OF BALTIMORE D50364

CERTIFICATE OF DEATH. 109

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 E. Monument ST.; 10 WARD)

2-FULL NAME Jennie Collins

(a) RESIDENCE. No. 957 N. Collington Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Joseph Collins

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Ruley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mckenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Joseph Collins 1108 E Monument

15 Filed JAN 31 1921 ERNEST I KRAUTER Registrar Burial Permit 01694

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1921, to Jan 30 1921, that I last saw h[illegible] alive on Jan 31 1921, and that death occurred, on the date stated above, at 9 4, m.

The CAUSE OF DEATH* was as follows:

acute Intestinal ob struction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Findings

(Signed) A. G. Hornstein, M. D.

1/30, 1921 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore.	Feb 1 1921
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1950365 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950365

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 545 N. Fulton Ave (St.) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice May Charles

(a) RESIDENCE. (No.) 545 N. Fulton Ave (St.) (Ward.)
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Rue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel Charles
(Address) 545 N. Fulton Ave

15 Filed JAN 31 1921 . 19 ROBERT J. KRAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1920, to Jan 29, 1921, that I last saw h[er] alive on Jan 29, 1921, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. Thomas Nelson, M. D.

, 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 1 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. Norths[illegible]

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50366 HEALTH DEPARTMENT—CITY OF BALTIMORE D50366

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 702 Melrose Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Walker

(a) RESIDENCE. No. 702 Melrose Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Walker

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer L. L. Evans

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Florence Walker

(Address) 702 Melrose Ave

15 Filed JAN 31 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 28, 1921, that I last saw h alive on Jan 28, 1921, and that death occurred, on the date stated above, at 5 P. .m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulm Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Records

(Signed) , M. D.

Jan 29 1921 (Address) 1037 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 31 1920

20 UNDERTAKER John H. Toadvine ADDRESS 1412 Ward St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050367 HEALTH DEPARTMENT—CITY OF BALTIMORE 050367

CERTIFICATE OF DEATH. 130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Goold St.: 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Burton

(a) RESIDENCE. No. 630 Goold St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgiana Burton

6 DATE OF BIRTH (month, day, and year) March 16, 1860?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dockman. 074

(b) General nature of industry, business, or establishment in which employed (or employer) Loading Ships.

(c) Name of employer Jos. Rose Son Transportation Co.

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Va.

PARENTS

10 NAME OF FATHER Levin Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Va

12 MAIDEN NAME OF MOTHER Lucy —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co Va.

14 Informant Georgiana Burton
(Address) 630 Goold St.

15 Filed ....., 19.... [illegible] Registrar

JAN 31 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Jan 28, 1921, that I last saw h[illegible] alive on Jan 27, 1921, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis.
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Physical

(Signed) W. S. Wright, M. D.

Jan 28, 1921 (Address) 1709 Preston.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 31 1921
20 UNDERTAKER	ADDRESS
Edw. Pug gold	1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

L050368 HEALTH DEPARTMENT—CITY OF BALTIMORE 8m L050368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital St.: 21 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Mason

(a) RESIDENCE. No. 2030 Etterbein St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Mason

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant City Hospital Records (Address)

15 Filed JAN 31 1921 ROBERT E. KRAUTER Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Jan 29, 1921, that I last saw h.er alive on Jan 29, 1921, and that death occurred, on the date stated above, at 8:05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

0040

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) G. C. Medaby, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Feb 2 1921

20 UNDERTAKER Edw. Ruggold — ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history.
Not known.

1050369 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 540 Oxford St. 17 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Ockmey

(Residence in Baltimore: No. 540 Oxford St

St.; yrs., 56 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-[redacted], WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Jan 18, 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work musician
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Aaron Ockmey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Matilda Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss E. V. Ockmey

(Address) 1217 Division St

15- FILED JAN 31 1921, 191... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 5 mins

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 28, 1921 (Address) 2807 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemty — DATE OF BURIAL, Jan 31st, 1921

20-UNDERTAKER Geo H Ha Aland — ADDRESS 1231 Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050370 HEALTH DEPARTMENT—CITY OF BALTIMORE 050370

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 238 S Patterson park ave. WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Wever

(a) RESIDENCE. No. 238 S Patterson park ave WARD. 1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Wever

6 DATE OF BIRTH (month, day, and year) Nov 11 1853

7 AGE 67 Years 2 Months 19 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Wever 238 S Patterson park ave

15 Filed JAN 31 1921 ROBERT P. PRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 30, 1921, that I last saw her alive on Jan 29, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Signs

(Signed) C. C. Calder, M. D.

1/30/21 (Address) 142 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Feb 2 1921
20 UNDERTAKER	ADDRESS
Louis Heemann	32 S Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050371 HEALTH DEPARTMENT—CITY OF BALTIMORE 050371

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dudek.

(a) RESIDENCE. No. 3725 Foster Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dudek.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Dudek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Barbara Niemann (Address) 3703 Fait Ave.

15 Filed JAN 31 1921 ROBERT B KRAUTH Registrar

Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1921, to Jan. 29, 1921, that I last saw him alive on Jan. 29, 1921, and that death occurred, on the date stated above, at 12-20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 1 1921
20 UNDERTAKER Lilly & Zeller.	ADDRESS 403 S. Wolfe St

PLACE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050372 HEALTH DEPARTMENT—CITY OF BALTIMORE 050372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Orleans ST.; 6 79 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Douglas

(a) RESIDENCE. No. 1926 Orleans ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Wm R. Douglas

6 DATE OF BIRTH (month, day, and year) April 9-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Fohle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs James Johnson

(Address) 1926 Orleans St

15 JAN 31 1921 ROBERT A KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 29 1921, that I last saw h[illegible] alive on Jan 29 1921 and that death occurred, on the date stated above, at 5-29 P m.

The CAUSE OF DEATH* was as follows:

Cardiac asthma

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Progressive Cardiosclerosis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J Cook M. D.

1/29, 1921 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 1 1921
20 UNDERTAKER John F Denny	ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

L050373 HEALTH DEPARTMENT—CITY OF BALTIMORE L050373

CERTIFICATE OF DEATH. 167

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. St Agnes Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Kuhn

(Residence in Baltimore: No. 1437 Columbia Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	White	Single

6-DATE OF BIRTH, May (Month) 10 (Day), 1917 (Year)

7-AGE, 3 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 100

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER, Charles Kuhn

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Nettie Golden

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Nettie Kuhn

(Address) Cherry Hill Westport

15- FILED JAN 31 1921 ROBERT J. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

2d Burns and 1/3 body while playing around Bon fire Accident

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Peebles M. D. (Coroner.)

Jan 30, 1921 (Address) 701 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Cherry Hill Westport

Former or usual residence 1437 Columbia ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 1, 1921

20-UNDERTAKER Josiah Lippa — ADDRESS 1600 Monroe ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050374 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050374

CERTIFICATE OF DEATH. 6-041

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francisgek Jokin

(a) RESIDENCE. No. 2826 Dillon ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1919 - Oct 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General natnre of Indnstry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Jokin

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or conntry) Poland

12 MAIDEN NAME OF MOTHER Bronia Pruszka

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country) Poland

14 Informant Frank Jokin
(Address) 2826 Dillon St

15 Filed JAN 31 1921 ROBERT I. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Jan 30, 1921, that I last saw h.. alive on Jan 30, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Hearts

(dnration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(dnration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an antopsy?

What test confirmed diagnosis? Autopsy

(Signed) M. Mutyala, M. D.

Jan 31, 1921 (Address) 600 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 31, 1921

20 UNDERTAKER Stephen J Frankowski ADDRESS 1005 S Conkling

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 50375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 50375

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Gen. Hosp. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R. Smith

(Residence in Baltimore: No. 1437 E. Fairmount St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, March 2, 1886
(Month) (Day) (Year)

7-AGE, 34 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Francis A. Cooper

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Martha Matson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. R. Smith

(Address) 1737 E. Fairmount Av

15- JAN 31 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Medical negligence

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) (Surgical shock) Complication of Infection of soft tissues,

1 1 hrs. (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. D. Hennessy M. D.
(Coroner.)

Jan. 29, 1921 (Address) 2800 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Feby 1, 1921
20-UNDERTAKER	ADDRESS
Hennegy & Co	2108 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

with breast. – Not cancerous or septicaemia

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50376 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.Public Health Service Hospt #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry, Balto. Md ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME RALPH W. WIGNER

(a) RESIDENCE. No. U.S.Public Health Service ST. Hospt #56 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	22	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) W.Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rambo Registrar
(Address) USPHSH.#56, Ft.McHenry, Md.

15 Filed JAN 31 1921 19 ROBERT I. KRAUTER Acting Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1921, to Jan. 30, 1921, that I last saw him alive on Jan. 30, 1921, and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic pulmonary

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ------

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Thomas B. Payne Senior Surgeon

19 (Address) USPHSH.#56, Ft.McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W. Va	Jan 31 1921

20 UNDERTAKER J. Guisman Bro ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50377 HEALTH DEPARTMENT—CITY OF BALTIMORE D50377

CERTIFICATE OF DEATH. 138

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanora C. Lehrer

(a) RESIDENCE. No. 1803 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas P. Lehrer

6 DATE OF BIRTH (month, day, and year) Apr. 31. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Jeremiah McCaure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hanora McCaure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas P. Lehrer

(Address) 1903 W. Lexington

15 Filed JAN 31 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 31, 1921, that I last saw h W alive on Jan 31, 1921, and that death occurred, on the date stated above, at 5.30A m.

The CAUSE OF DEATH* was as follows:

Nephritis
(7½ mos pregnant)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) uraemic Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine etc.

(Signed) J. C. Saund, M. D.

1-31 1921 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 2 1921
20 UNDERTAKER John J. Falls	ADDRESS 1200 W. Fayette

TION is very important. See instructions on back of

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050378 L050378 131 L050378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... St.; ..... Ward)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jennie Moffet

(a) RESIDENCE. No. ..... Forest Hill, Md. St., ... Ward. Fristhill-Harford Co. Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? 52 yrs. 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1869

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
52	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework for self at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland.

PARENTS

10 NAME OF FATHER William Moffet

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) Not known

14 Informant Rhoads U. P. S.

(Address) Dorsey St.

15 Filed JAN 31 1921 ROBERT E. GRAETZER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1921, to Jan. 31, 1921, that I last saw her alive on Jan. 31, 1921, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Myomata of Uterus.
Cyst of ovary.

(duration) 3/12 yrs. mos. days.

CONTRIBUTORY (Secondary) Intestinal obstruction.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 28, 1921.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) T. H. Zimmerman, M. D.

Jan 31 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Hill - Md	Jan 31 1921.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not cancerous

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50379 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50379

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N Calhoun ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Howard Brown

(a) RESIDENCE. NO. 1144 N Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Essie Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Essie Brown

(Address) 1144 N Calhoun

15 Filed JAN 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from December 9, 1920, to Jan 29, 1921, that I last saw him alive on Jan 28, 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Pk Thisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) H. S. McCard, M. D

1/29, 1921 (Address) 2008 Dekalb av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dame's Quarter Church	1/31 1921
20 UNDERTAKER	ADDRESS
Jno. H. Bruce & Co	1 [illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50380

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Poplar Grove ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claudius W. Lyon

(a) RESIDENCE. No. 1014 Poplar Grove ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	7	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Guy O. Lyon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Center Point W. Va

12 MAIDEN NAME OF MOTHER Mary Davison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Center Point W. Va

14 Informant Guy O. Lyon
(Address) 1014 Poplar Grove St.

15 Filed . 19 Robert P. Harrison, Registrar

N31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1921, to Jan 30, 1921, that I last saw him alive on Jan 30, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Congenital heart Disease
(malformation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 1 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50381 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50381

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH Boyview Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.: 8 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Macauley

(a) RESIDENCE. No. 1805 N. Chester St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	37.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Do
12 MAIDEN NAME OF MOTHER Do.
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margt Record
(Address) Boy View Baltimore

15 Filed JAN 31 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1921 to Jan 29 1921.
that I last saw him alive on Jan 28, 1921.
and that death occurred, on the date stated above, at 2.00 a.m.
The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane).

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fracture Dislocation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Autopsy
(Signed) H. Goldsmith M. D.
1/29/1921 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2/1 1921
20 UNDERTAKER	ADDRESS
Geo A Farley Funeral Parlors	Baltimore

MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50382

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Eutaw St; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Johnson

(Residence in Baltimore: No. 710 Raborg St; St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Don't Know (Day) ....., 1881 (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Danville Va

PARENTS.

10-NAME OF FATHER, Rose Johnson

11-BIRTHPLACE OF FATHER (State or Country), Danvill Va

12-MAIDEN NAME OF MOTHER Mary Green

13-BIRTHPLACE OF MOTHER (State or Country), Danvill Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucie Johnson

(Address) 710 Eutaw St.

15-

Filed JAN 31 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 29 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921, to Jan. 28 1921, that I saw h.... alive on " 28 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Nephritis

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY. Endocarditis
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J. H. Pfeiffer M. D.

Jan 31, 1921 (Address) 13 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Feb 1, 1921
20-UNDERTAKER	ADDRESS 113 W
Brown & Sheeland	Lexington St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50383

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Addie Heritage.

(a) RESIDENCE. No. 203 Gilmer St. Burlington, N.C. WARD. Burlington N.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Carl V Heritage

6 DATE OF BIRTH (month, day, and year) Oct. 30 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Louis Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lena Albright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant J. H. Hospital Records (Address)

15 Filed JAN 31 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921, to Jan 31, 1921, that I last saw h.Er alive on Jan 31, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(1) Brain tumor - cerebreo-pontine angle (L)

(2) Shock following exploratory craniotomy

(duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Shock following operation for Exploration of brain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N.C

Did an operation precede death? Yes Date of 1-28-21

Was there an autopsy? Yes

What test confirmed diagnosis? Tumor seen at operation

(Signed) I. H. Thomson, M. D.

1 31, 1921 (Address) Johns Hopkins Hosp. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burlington N.C.	Jan 31 21

20 UNDERTAKER H E Hughes ADDRESS 414 N. Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50384 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50384

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Wolf ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Pilek

(a) RESIDENCE. No. 120 S. Wolf ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (~~write the word~~)
Male	white	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk in 009

(b) General nature of industry, business, or establishment in which employed (or employer) Store Room Annex

(c) Name of employer American Can Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Leinl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Conrad Block Sons Viola & Block Co

15 Filed JAN 31 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1917 to Jan 30 1921 that I last saw him alive on Jan 29 1921 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 4 yrs.

(duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical

(Signed) Geo Heller M. D.

1/31 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Feb 1 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Paca

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Jews)

D.50385 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50385

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 114 S. Stockton ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Jews.

(a) RESIDENCE. No. 114 S. Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgeanna Jews

6 DATE OF BIRTH (month, day, and year) Oct 31-1858

7 AGE: Years 62 Months 2 Days 30 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer: Wallis Allen.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Hooper Jews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Georgeanna Jews

(Address) 114 S. Stockton

15 Filed JAN 31 1921 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 21 1921, to Jan 30, 1921, that I last saw him alive on Jan 29, 1921, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Lynch M. D.

Jan 31-1921 (Address) 1331 W North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Feb 1st 19
20 UNDERTAKER	ADDRESS
A. Jones	207 S. Stricker

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50386 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50386

CERTIFICATE OF DEATH. 37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 W. Fayette ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. R. Tyler

(a) RESIDENCE. No. 825 W. Fayette ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Nellie B. Tyler

6 DATE OF BIRTH (month, day, and year) Jan 9. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	0	20	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER William J. Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Nellie B. Tyler (Address) 825 W. Fayette St.

15 FEB-1 1921 ROBERT B. CRAWFORD Registrar Burial Permit Oly.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1921 to Jan 29 1921

that I last saw him alive on Jan 29 1921

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3. ds.

CONTRIBUTORY (Secondary) Syphilitic

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H N King M. D.

1-29 1921 (Address) 651 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 1 1921.

20 UNDERTAKER	ADDRESS
Jno & Mno. John W. Deufel & Son	801 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50387 — 28 — D 50387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Warner

(a) RESIDENCE. No. 1123 N. Stricker ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes L. Warner,

6 DATE OF BIRTH (month, day, and year) Sept 1-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Health Departmen

(c) Name of employer Balto City Health dept

9 BIRTHPLACE (city or town) Balto city
(State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Agnes L. Warner
(Address) 1123 N. Stricker St

15 Filed FEB 1 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to Jan 29, 1921, that I last saw him alive on Jan 29, 1921, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum positive

(Signed) Harry S. McCarty, M. D.

, 19 (Address) 37 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 1st 1921

20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

TION is very important. See instructions on back of certificates.

D50388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50388

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. S/S Norden. Port Covington. ST: 4 WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Booker.(C)

(Residence in Baltimore: No. 669 Raborg St. St.: 15 yrs., ---- mos., --- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored	Married.

6-DATE OF BIRTH, April 15th. 1884, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 9 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore. 074
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Richmond, Va.

PARENTS.

10-NAME OF FATHER, Spencer Booker.(C)

11-BIRTHPLACE OF FATHER (State or Country), Richmond, Va.

12-MAIDEN NAME OF MOTHER Charlotte ------(C)

13-BIRTHPLACE OF MOTHER (State or Country), Richmond, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Booker.(C) wife.

(Address) 669 Raborg St.

Filed FEB 1- 1921 191 ROBERT F KRAUTER Registrar.
Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the Skull.
Struck on the head by falling pipe
Accidental Death.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)
Jany. 29. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Feb 1 1921
20-UNDERTAKER Daniel Easton	ADDRESS 816 Canton

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very may be properly classified. PHYSICIANS should state in plain terms, so that it

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50389 HEALTH DEPARTMENT—CITY OF BALTIMORE D50389

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Macon ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Lewis

(a) RESIDENCE. No. 1024 A Parcas ST..... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER George F Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Carrie Schaaf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lee F Lewis

(Address) 1024 Parcas

15 FEB 1 - 1921 ROBERT J. KEISTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31- 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-31- 1921, to 1-31- 1921, that I last saw h wi alive on 1-31-21, 1921, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Failure of Forsmen Oval to Functionate

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rutland Downs, M. D.

1921 (Address) 1317 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Feb 1st 1921
20 UNDERTAKER John L Stubbs	ADDRESS 1200 N Fulton

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1250390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64-1250390

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 E. 26th ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanore C. Berry

(a) RESIDENCE. NO. 34 E 26th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswomen 066

(b) General nature of industry, business, or establishment in which employed (or employer) Flavoring Extracts

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jessie L. C. Berry

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Rooster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Emma Berry
(Address) 34 E. 26th St.

15 Filed . 19 SOLEY F KRAUTER Registrar

FEB 1 - 1921 Burial Permit 9168

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 31, 1921, that I last saw h[illegible] alive on Jan 30, 1921, and that death occurred, on the date stated above, at 7-30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Cerebral hemorrage from Embolic causes following Influenza (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Burns, M. D.

1-31-1921 (Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountain View	2/2/21 19
20 UNDERTAKER	ADDRESS
Chas E Franke	802 Madison Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 050391 ✓ 050391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 106 N. Chapel St.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa M. Steitag

(a) RESIDENCE. No. 106 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19/1864

7 AGE: Years 57 Months Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Weisel

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Steitag
(Address) 106 N. Chapel St.

15 Filed . 19 ROBERT E. SLAUTER Registrar

FEB 1 - 1921 Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 15, 1921, to Jany 29, 1921, that I last saw her alive on " " 1921, and that death occurred, on the date stated above, at 5 a.m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms only

(Signed) J. B. Ellenberg, M. D.

Feby 1st 1921 (Address) 1810 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb. 2 1921

20 UNDERTAKER: J. J. Kerr — ADDRESS: 156 N. Longwood

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1050392

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050392

80-010

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #2125 N. Charles St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arrianna Elizabeth Hance

(a) RESIDENCE. NO. #2125 N. Charles St. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 88 yrs. 6 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Benj. O. Hance

6 DATE OF BIRTH (month, day, and year) July-20-1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	88	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Maryland.

PARENTS

10 NAME OF FATHER Rev. Wm. T. Wilson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Maryland

12 MAIDEN NAME OF MOTHER Sarah S. Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Maryland

14 Informant Benj. O. Hance, (Son)
(Address) 2125 N. Charles St.

15 Filed FEB 1 - 1921 ROBERT I. ALANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 31, 1921.

that I last saw h... alive on Jan 31, 1921.

and that death occurred, on the date stated above, at 7 .....m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. ..... mos. 2 wks ..... ds.

CONTRIBUTORY (Secondary) Grip

(duration) ..... yrs. ..... mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. Carlson, M. D.

..... 19 (Address) 1603 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Plum Point, Calvert Co. Md.	Feb-2-/ 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050393 HEALTH DEPARTMENT—CITY OF BALTIMORE 050393

CERTIFICATE OF DEATH. 10-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 220 N Bradford ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie May Clarkson

(a) RESIDENCE. No. 220 N Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 6 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) July 15 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Five	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Leo Clarkson

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Frances Simms

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Francis Clarkson
(Address) 220 N Bradford

15 Filed FEB 1 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Jan 29, 1921, that I last saw h... alive on Jan 28, 1921, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Probable Influenza

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. D. Burns, M. D.

1921 (Address) 2 N. Bradford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Jan 2 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

TION is very important. See instructions on back of certificates. ...it may be properly classified. Exact statement of OCCUPA-

D50394 HEALTH DEPARTMENT—CITY OF BALTIMORE D50394

CERTIFICATE OF DEATH.

X 161-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2417 Harlem Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R Steinschild

(Residence in Baltimore: No. 2417 Harlem Ave.

St.: yrs., (3 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, Oct. 2, 1844 (Month) (Day) (Year)

7-AGE, 76 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Retired
(h) General nature of industry, business, or establishment in which employed (or employer) Shoemaker

9-BIRTHPLACE, (State or Country), Bavaria

PARENTS.

10-NAME OF FATHER, Steinschild

11-BIRTHPLACE OF FATHER (State or Country) Bavaria

12-MAIDEN NAME OF MOTHER Steinschild

13-BIRTHPLACE OF MOTHER (State or Country) Bavaria.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph D. Clarke

(Address) 2417 Harlem ave.

15-

FILED FEB 1 - 1921 ROBERT B BRAUER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by illuminating gas.

Probable (Duration) yrs. mos. 1 da. ds.

CONTRIBUTORY (Secondary) accident

(Duration) yrs. mos. ds.

(Signed) J. S. D. Hennessy M. D. (Coroner.)

Jan 31 1921 (Address) 2802 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2417 Harlem Ave yrs. 3 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2417 Harlem Ave. Residence

Former or usual residence 1015 Broadway

19-PLACE OF BURIAL OR REMOVAL, Indianapolis Ind

DATE OF BURIAL, Feb 1, 1921

20-UNDERTAKER Wm J Ecknerson

ADDRESS N Y Pa

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1950395 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 1950395

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N. Glover ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Wakefield

(a) RESIDENCE. No. 620 N. Glover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 3/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Albert Wakefield

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Pinkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Albert Wakefield 620 N. Glover

15 Filed FEB 1 - 1921 ROBERT A KRAUTH Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15 1921 to January 31 1921, that I last saw him alive on January 27th 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonitis. — about 2 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no. Digestive disturbance

What test confirmed diagnosis?

(Signed) Amelia E. Tuck, M. D.

, 19 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Feb 2 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

050396

HEALTH DEPARTMENT—CITY OF BALTIMORE

050396

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 S Chester ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felica Dipete

(a) RESIDENCE. No. 115 S Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Donatro Dipete

6 DATE OF BIRTH (month, day, and year) Sept 15th 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Peter J. Dipete (Address) 115 S Chester

15 Filed FEB 1 - 1921 19 ROBERT B LEAVITT Registrar

Burial Permit 01084

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1920, to Jan. 30, 1921; that I last saw her alive on Jan 27, 1921, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno, M. D.

Jan. 31, 1921 (Address) 2314 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 2/21
20 UNDERTAKER	ADDRESS
Wendell Duff & Son	37 S Mun

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050397

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 050397

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1151 E Lombard St. 3d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Weiman

(Residence in Baltimore: No. 1951 E. Lombard St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH, May 2, 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardner 040
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Factory

9-BIRTHPLACE, (State or Country), City Balto

PARENTS.

10-NAME OF FATHER, John Weiman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Weiman

(Address) 1151 E. Lombard

15-

Filed FEB 1 1921, 191.. Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 21 1921, to Jan 30 1921, that I saw h mr alive on Jan 29 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Malaria

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion & Nephritis

(Duration) ....yrs. 3 mos. ....ds.

(Signed) Alfred A. Bruback M. D.

Jan 30, 1921 (Address) 845 Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Feb 2, 1921

20-UNDERTAKER Wendell Appel & Son

ADDRESS 37 S Fm

(If DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, the OCCUPATION is very important. See instructions on back of certificate.)

A50398 HEALTH DEPARTMENT—CITY OF BALTIMORE A50398

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1217 Maryland Ave or on way from my to 80 ST. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John M. Dimmott

(Residence in Baltimore: No. 245 - N Pulaski St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W	?

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 3 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Automobile worker
(b) General nature of industry, business, or establishment in which employed (or employer): 056

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Baltimore

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Baltimore

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Frost

(Address) 245 N. Pulaski

15 FEB 1 - 1921 Filed ....., 191.... ROBERT F. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) M.D. Ashby M. D. (Coroner.)

Feb 1, 1921. (Address) 1007 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Feb 2, 1921
20-UNDERTAKER W M Roulson	ADDRESS 2301 Greene ~~Feb 2 21~~

Important. See instructions on back of certificate. Cases must be properly classified. Exact statement of OCCUPATION is very

1050399 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Rear 1601 Monument & Asph. St., 13 28 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Keyser

(Residence in Baltimore: No. Monument & Asph. St. If not, how long in city, yrs., mos., ds.) 20 yrs

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH April 18, 1881
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer). 079

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos. F. Keyser

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Regie Corper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Chesser

(Address) 307 Fallsway

15- FEB 1 - 1921 ROBERT P. LAMBERT
Filed ..... 191.... Burial Permit Issued
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st Uremia (Chronic)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emil Hoerner M. D.
(Coroner.)

Jan 30, 1921 (Address) 763 Rolland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Marys Hampden

DATE OF BURIAL, Feb 2, 1921

20-UNDERTAKER Churchwell & Son

ADDRESS Chestnut Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1950400

HEALTH DEPARTMENT—CITY OF BALTIMORE

1950400

CERTIFICATE OF DEATH

Certificate of OCCUPATION is very important. See instructions on back of certificate.

Certificate 91 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cedar & Locust Ave St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Edward Schmidt Jr.

(Residence in Baltimore: No. Everlee, Balto St.; ...yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	W.	✓

6-DATE OF BIRTH, March (Month) 21 (Day), 1920 (Year)

7-AGE, ...yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Harry B Schmidt Jr.

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Harriet V. Fahrman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Schmidt

(Address) Cedar Ave

15- Filed FEB 1 - 1921 191... ROBERT J KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 28 1921, to Jan 31 1921, that I saw him alive on Jan 31 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchs- Pneumonia

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Teething

(Duration) ...yrs. ...mos. ...ds.

(Signed) Gustave A Fiat M. D.

2/1, 1921 (Address) Everlee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Comm — DATE OF BURIAL, Feb 3 1921

20-UNDERTAKER Chenoweth Son — ADDRESS Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Blks.

C 50401

HEALTH DEPARTMENT—CITY OF BALTIMORE

C 50401

CERTIFICATE OF DEATH.

REGISTERED NO. C 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 E. Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Henry Broring

(Residence in Baltimore: No. 2630 E. Madison St. St.; 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1842 (Year)

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, B. H. Broring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorothea Bohn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Broring

(Address) 2630 E. Madison St

15-Filed FEB 1 - 1921, 191 ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 29, 1920, to Jan. 30, 1921, that I saw him alive on Jan. 30, 1921, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

No hemorrhage

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Zenby, M. D.

Jan. 31., 1921. (Address) 223 N. Catalina St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Newbacharal Com

DATE OF BURIAL, 2-2, 1921.

20-UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

Instructions on back of certificate.

Statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50402 HEALTH DEPARTMENT—CITY OF BALTIMORE D50402

CERTIFICATE OF DEATH. +6-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice Mullen

(a) RESIDENCE. No. — none — ST., ... WARD. Charlotte, N.C.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 1 mo. — ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mullen

6 DATE OF BIRTH (month, day, and year) aug 26-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Fort Worth (State or country) Texas.

PARENTS

10 NAME OF FATHER — Rudeck

11 BIRTHPLACE OF FATHER (city or town) Frankfort, (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Frankfort (State or country) Germany

14 Informant Mildred Potts (Address) 500 S Third St

15 FEB 1-1921 ROBERT N. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1921, to Jan 28, 1921, that I last saw h.r alive on Jan 28, 1921, and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia, acute nephritis, septicaemia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. MacGowan M. D.

1/29/1921 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holly Cross, Com Harford Rd	Feb 1 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Fath av

TION is very important. See instructions on back of certificates. If may be properly classified. Exact statement of OCCUPA-

D50403 HEALTH DEPARTMENT--CITY OF BALTIMORE D50403

CERTIFICATE OF DEATH

120 REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1427 Hanover St. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Bamberger

(Residence in Baltimore: No. 1427 Hanover St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Nov 1, 1862 (Month) (Day) (Year)

7 AGE: 58 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John T. Baldwin

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Bryan

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lillie Burke

(Address) 1427 Hanover

15 Filed FEB 1 - 1921 ROBERT A KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 30, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1920, to January 30 1921, that I saw her alive on January 30, 1921, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY) Interstitial Nephritis

(Duration) 1 yrs. 7 mos. ds.

(Signed) A M Bracklein M. D.

, 191 (Address) 1318 S Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL: Feb 2nd, 1921

20 UNDERTAKER: Deckelman & Son — ADDRESS 1039 Hanover St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D.504404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.504404

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST.: 18 WARD)

2-FULL NAME Miedreg Wharton

(a) RESIDENCE. No. Nursery & Child's Hospital ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5 mo	1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Employed.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Ross Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Grace Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Maryland

14 Informant (Address) Mrs. George A. Hylton 2416 Hospital School Annex Sinclair Ln.

15 Filed Robert P. Harrison, Registrar
1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1921, to Feb. 1, 1921, that I last saw h[illegible] alive on Feb. 1, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Ovrd

Nutritional Decomposition

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Finglass, M. D.

, 19 (Address) 2002 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 2, 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

IMPORTANT is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50405 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50405

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 0919 Mc Eldrey St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Pfeiffer

(a) RESIDENCE. No. 2219 Mc Eldrey ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter

6 DATE OF BIRTH (month, day, and year) aug 24 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22 years 5 m 8 d	22	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Concord N. Hampshire

PARENTS

10 NAME OF FATHER Nathan Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Ferber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J Lewis 1411 E Baltimore

15 Filed B 1-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1921, to Feb. 1st, 1921, that I last saw her alive on Jan. 31, 1921, and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. D. Reed, M. D.

2/1, 1921 (Address) 408 S Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrendeck Road	2/2 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50406 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50406

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Balto. General Hospital. WARD) 4 X 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Linwood M. Bezemore.

(Residence in Baltimore: No. 649 W. Fayette St. St.: yrs. ---- mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, ...December 15th. 1920...., 1.....
(Month) (Day) (Year)

7-AGE, ...---yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lewiston, N.C.

PARENTS.

10-NAME OF FATHER, Walter C. Bezemore.

11-BIRTHPLACE OF FATHER (State or Country), Lewiston, N.C.

12-MAIDEN NAME OF MOTHER Mary B. Casper.

13-BIRTHPLACE OF MOTHER (State or Country), Lewiston, N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter C. Bezemore, (father)

(Address) 649 W. Fayette St.

15- Robert P. Harrison,
Filed ..... 191.....
FEB 1 - 1921 Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...January 31st. 1921....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquiry.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....inquiry.... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
.....Mitral Insufficiency.....
.....congenital.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

Jan. 31, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
649 W. Fayette St.

Former or usual residence.....Lewiston, N.C.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
KELFORD - NC Via Old Bay Line - Atlantic Coast Ls	FEB 1, 1921
20-UNDERTAKER JOHN F. DENNY	ADDRESS 716 LIGHT ST.

important. See instructions on back of certificate.

D.50407

D.50407

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 W. Ostend ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Faid

(a) RESIDENCE. No. 2 W. Ostend ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edel M Faid

6 DATE OF BIRTH (month, day, and year) July 7 1889

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
31	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Farm

(c) Name of employer J. F. Albert

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Faid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna E Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Seaford Del

14 Informant Mrs M Faid

(Address) 2 W Robert & Entlich.

15 Filed ..... 19 ..... Registrar

B1-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921 to Jan 31, 1921, that I last saw h i alive on Jan 31, 1921, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumd.

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) X X

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? In home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) A Hill Burke M.D. M. D.

, 19 (Address) 340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cmetry	Feb 3 1921
20 UNDERTAKER	ADDRESS
Wm F Bamy.	715 Light St

IMPORTANT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50408 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50408

CERTIFICATE OF DEATH.

REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3113 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth D. Dobart

(a) RESIDENCE. No. 3113 Dillon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27. 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robt. a. Dobart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Anna Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Robt. a. Dobart
(Address) 3113 Dillon St.

15 Filed ..., 19 Robert P. Harrison, Registrar

FEB 1 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1920, to Feb 1, 1921, that I last saw her alive on Feb 1, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Oedema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Harvey B Titlow, M. D.

2/1, 1921 (Address) 315 S. Highland ave

*State the Disease Causing Death, or (in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Feb. 2 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

TION is very important. See instructions on back of certificates.

D.50409 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50409

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 127 S. E. Elwood St.; WARD) REGISTERED No. C

2-FULL NAME Caroline Kuhn

(Residence in Baltimore: No. 127 S. Elwood St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: Oct 9, 1857 (Month) (Day) (Year)

7-AGE: 66 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (State or Country): Not known

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius M. Berger

(Address) 3004 O'Donnell St.

15- FEB 1 - 1921 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto Fuller M. D. (Coroner.)

2-1-21 (Address) 4 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Schwartz's cem. DATE OF BURIAL: Feb 5, 1921

20-UNDERTAKER: Zirkler & Zirkler ADDRESS 1739 E. Lager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D.50410 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50410

CERTIFICATE OF DEATH. 184

REGISTERED No. C

1-PLACE OF DEATH Found in sewer at

CITY OF BALTIMORE (No. Kearney & Cary ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Col	S

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE. About 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. unknown
(b) General nature of industry, business, or establishment in which employed (or employer).

601

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison,

Filed....., 191.....

FEB 1 - 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 29, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

unknown Cause of Decomposed Body taken Photo, & no Signs Could be discovered

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James W. Smith M. D. (Coroner.)

Jan 29, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....

20-UNDERTAKER ADDRESS

JAN 31 1921

Commissioner Health.

Ptr. Wm. E. WOODALL

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.50411 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50411

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fed. Mil. Hosp. ST.: | | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones.

(a) RESIDENCE. NO. 1618 Eutaw Place ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13-1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Jones.

11 BIRTHPLACE OF FATHER (city or town) Fort Wayne
(State or country) Indiana

12 MAIDEN NAME OF MOTHER Cecilia Deutzerar

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant
(Address) Robert P. Harrison, JOHNS HOPKINS HOSPITAL

Filed FEB 1 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1920.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1920, to Jan. 28, 1920, that I last saw him alive on Jan. 28, 1920, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 15 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinically.

(Signed) Fred B. Smith, M. D.

19 (Address) Fed. Mil. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL FEB 1 1921 19

20 UNDERTAKER Commissioner Health, ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50412 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50412

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 9 ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip A. DeBaugh.

(a) RESIDENCE. No. 2202 Monticello Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida DeBaugh

6 DATE OF BIRTH (month, day, and year) June 21st 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country) Unknown

14 Informant Mrs Ida D. DeBaugh (Address) 2202 Monticello Ave.

15 Filed Robert P. Harrison, Registrar

2-1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921, to Feb 1, 1921, that I last saw him alive on Feb 1, 1921 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy (Probably malignant).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 20, 1921

Was there an autopsy? No.

What test confirmed diagnosis

(Signed) J. A. Schenck, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery	Feb 3 1921
20 UNDERTAKER	ADDRESS
Fred. Ingram & Son	Baltimore

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50413

CERTIFICATE OF DEATH.

X 51

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Judy

(a) RESIDENCE. NO. Somerset Pa ST., WARD Somerset Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. 36 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter H. Judy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Walter Clock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Mary Edmunds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Walter Judy
(Address) Somerset Pa

15 Filed ..... 19.... Robert P. Harrison, Registrar

FEB 1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1-1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1921, to Feb 1, 1921, that I last saw h[illegible] alive on Feb 1, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Opothalmic goitre.

3
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Somerset Pa

Did an operation precede death? Yes Date of Feb 1st

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. McCraig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Summerset Pa	2-1-1921
20 UNDERTAKER	ADDRESS 17 S.
Robert Brooks & Son	Calhoun st.

FIRM is very important. See instructions on back of certificates.

D.50414 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50414

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1823 bins ST. 70 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Kee

(Residence in Baltimore: No. 1823 bins St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Oct (Month) 2 (Day), 1903 (Year)

7-AGE, 17 yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 070
(a) Trade, profession, or particular kind of work: Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer): Institution

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, John Kee

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Susie McGriff

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kee

(Address) 1823 bins St

15-

Filed FEB 1-1921, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Jan 31, 1921 (Address) 200 E Clay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 2, 1921
20-UNDERTAKER	ADDRESS
Broome & Tidland	1140 Schroeder

IMPORTANT: PHYSICIAN is required by law to report to the Health Department the cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

45408
D.50415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50415

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Rafael Salas.

(a) RESIDENCE. NO..... Savannah Georgia ST., ... WARD. Savannah Ga.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary J. Salas.

6 DATE OF BIRTH (month, day, and year) Dec 31-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Ramon Salas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Catherine P. Pongiand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant (Address) J. Hopkins Hospital Records

15 Filed FEB 1-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 31, 1921, that I last saw h[illegible]alive on Jan 31, 1921, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 4 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Embolism - pulmonary (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) W. A. Bailey, M. D.

....., 19... (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savannah Ga.	Feb 1st 1921
20 UNDERTAKER Kelly + Zeiler	ADDRESS 4033 W. Fay...

TION is very important. See instructions on back of certificates. ... at it may be properly classified. Exact state ... of OCCUPA-

20.50416 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50416

CERTIFICATE OF DEATH.

174

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Plant, Balto. Dry Docks & Ship Bldgs Co. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Kacanko.

(Residence in Baltimore: No. 244 S. Eden St.)

St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single.

6-DATE OF BIRTH: Do not know. (Month), (Day), 1 (Year)

7-AGE: 34 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): O.H.D.

9-BIRTHPLACE, (State or Country): Russia.

PARENTS.

10-NAME OF FATHER: Do not know.

11-BIRTHPLACE OF FATHER (State or Country): Do not know.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pete Kacanko.

(Address) 135 S. Central Ave.

15-

Filed FEB 1 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31st. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Crushed about the chest by a revolving crane. Accidental Death.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hy M. Reinhardt M. D.
(Coroner.)

Jan 31 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Potomac Cem. DATE OF BURIAL: Feb 3, 1921

20-UNDERTAKER: John F. Denny ADDRESS: 715 Light St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. PHYSICIANS should state plain terms, so that it may be

D.50417 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 X 159 WARD)
REGISTERED No. C .....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert McGill Hudson
(Residence in Baltimore: No. Harvard Co St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Sgle

6-DATE OF BIRTH, June (Month) 9 (Day), 1897 (Year)

7-AGE, 21 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Int
(b) General nature of industry, business, or establishment in which employed (or employer) Farm

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, A. Hudson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER M Grimsley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Johnson
(Address) Harvard Co

15- Robert P. Harrison,
Filed ....., 191.... Registrar.
FEB 1-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by Strychnine
Coma (Duration) ....yrs....mos....ds.
CONTRIBUTORY (Secondary) ?
(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)
Feb 1, 1921. (Address) 1629 Key

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?....
Former or usual residence Residence Howard Co Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Providence M E Howard Co.	2/2/21, 19....

20-UNDERTAKER Easton Sons ADDRESS Ellicott City Md.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

050418

HEALTH DEPARTMENT—CITY OF BALTIMORE

050418

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Rutter ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Robinson

(Residence in Baltimore: No. 1422 Rutter St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, ... unknown ....., ... 1 .....
(Month) (Day) (Year)

7-AGE, ... — ..... yrs. ..... 1 ..... mos. ..... — ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Gilbert Robinson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Celia Harris

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert Robinson

(Address) 1422 E. Rutter St.

15-Filed FEB 2 - 1921, 191... ROBERT B BRAUER Registrar

Serial Firm Record

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 1 ..... — ..... 31 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to Jan 31 1921, that I saw h[illegible] alive on Jan 30, 1920, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. ..... 6 ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. Paul Stark M. D.

Feb 1, 1921. (Address) 1354 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	2/2/1921
20-UNDERTAKER	ADDRESS
Wm R Elliott	1725 Ashland Av

IMPORTANT.—See instructions on back of certificate.

Lafawer

D50419 HEALTH DEPARTMENT—CITY OF BALTIMORE D50419

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1505 W Fayette St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Lafawer

(Residence in Baltimore: No. 1505 W Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
mal	wht	mrd

6-DATE OF BIRTH, Oct (Month) 8 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 0 mos. 24 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Henry Lafawer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Yarbrough

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Emily Lafawer

(Address) 1505 W Fayette St

15-FEB 2-1921 ROBERT B KRAUTER

Filed....., 191.... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James W Poulson (Coroner.) M. D.

Feb 1, 1921 (Address) 1001 Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Pulas	Feb....., 1921
20-UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard St

Important. See instructions on back of certificate. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

McDaniel

D50420

HEALTH DEPARTMENT--CITY OF BALTIMORE

D50420

151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 58 Hanover ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of R. B. & Hannah McDaniel

(Residence in Baltimore: No. 58 Hanover ave St.; ..... yrs., ... mos. 6 hours ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 1, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, 6 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm B McDaniel

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Minnie S Hersch

13-BIRTHPLACE OF MOTHER (State or Country). Rock Hall Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr B McDaniel

(Address) 58 Hanover ave

15- FEB 2 - 1921
Filed ....., 191.....
ROBERT J. KRAUTER
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 1 1921, that I saw h... alive on Feb 1 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Mother G P Multip

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma G

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph C Mason M. D.

Feb 1, 1921. (Address) 1522 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Feb 2, 1921

20-UNDERTAKER	ADDRESS
John J Fields	1208 W Lombard

important. See instructions on back of certificate.

D50421 HEALTH DEPARTMENT—CITY OF BALTIMORE D50421

CERTIFICATE OF DEATH.

REGISTERED No. C 56

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 343 Courtland ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Terence Kelly

(Residence in Baltimore: No. 343 Courtland St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, about 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fireman 261
(b) General nature of industry, business, or establishment in which employed (or employer) Steam

9-BIRTHPLACE, (State or Country) Md

PARENTS.

10-NAME OF FATHER, Owen Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary McShane

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Kelly

(Address) 317 Albemarle

15- FEB 2 - 1921 ROBERT J. KRAUTER Filed ..... 191... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cause of death: W.P. pneumonia by Autopsy Dr Thos recent report of Chem. ~~Contains~~ Analysis not given Cause of death

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) NONE

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Jan 31, 1921. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	Feby 3rd, 1921
20-UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Fay ette

Important. See instructions on back of certificate. Should state properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Eks.

N 50422

HEALTH DEPARTMENT—CITY OF BALTIMORE

N 50422

28

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 N. Charles ST. 12 WARD)

2-FULL NAME Joseph Paul

(a) RESIDENCE. (Usual place of abode) NO. 2210 N. Charles ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. 5 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Mrs. Gertrude Paul

6 DATE OF BIRTH (month, day, and year) Aug. 30. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	5	1	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work President of the

(b) General nature of industry, business, or establishment in which employed (or employer) J. F. H. Dorman Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buffalo N. Y.

PARENTS

10 NAME OF FATHER Matthew Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Catherine Gebel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14 Informant Mrs. Gertrude Paul

(Address) 2210 N. Charles

15 Filed FEB 2 - 1921 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug, 19 15, to Jan 31st, 19 21,

that I last saw him alive on Jan 31st, 19 21,

and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. A. Blackford, M. D.

Feb 1st 1921 (Address) 40 E. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 3rd 1921
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E. Eager St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Dr. Green. Altoona Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

N 50423

N 50423

CERTIFICATE OF DEATH.

9r

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Evergreen Ave ST.: Hamilton 7 WARD)

2-FULL NAME Henry C Stahm

(a) RESIDENCE. No. 4 Evergreen Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Molly A Stahm

6 DATE OF BIRTH (month, day, and year) May 5- 58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 08

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Stahm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Molly Stahm (Address) 4 Evergreen Ave

15 FILED FEB 2 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 19, 1921, to Jany 30, 1921.

that I last saw him alive on Jany 30, 1921

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Left)

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (Left)

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

2/1, 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Feb. 2 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

A50424 HEALTH DEPARTMENT--CITY OF BALTIMORE A50424

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 4 Talbott Road ST.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Pels.

(Residence in Baltimore: No. 4 Talbot Road St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE: 73 yrs. mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Stock Broker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Simon Pels

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Fetta Coopman

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henrietta Pels

(Address) 4 Talbot Road

15. Filed FEB 2 - 1921, 19.. BOARD OF REGISTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan (Month) 31 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1921, to, Jan 31" 1921, that I saw h.. alive on Jan 30, 1921. and that death occurred, on the date stated above, at 3.30 A. m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 20 yrs. mos. ds

Contributory (SECONDARY) Indigestion

(Duration) yrs. mos. 1. ds.

(Signed) Herbert E. Zepp M. D.

Feb 1", 1921. (Address) 2000 North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Virginia

DATE OF BURIAL: Feb 2, 1921

20-UNDERTAKER: J. Ahern & Co

ADDRESS: 1611 Mad ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50425 HEALTH DEPARTMENT—CITY OF BALTIMORE D50425

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 St. Paul ST.: 17th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thompson Ash

(a) RESIDENCE. No. 2824 St Paul ST., 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 82 yrs 0 mos 28 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Augusta Ash

6 DATE OF BIRTH (month, day, and year) Jan-4-1839

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired from Shoe Manufacturing Industry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenwood Massachusetts

PARENTS

10 NAME OF FATHER James M. Ash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Massachusetts

12 MAIDEN NAME OF MOTHER Penelope White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Massachusetts

14 Informant (Address) Mrs Evelyn A. Ash (wife) 2824 St Paul St.

15 FEB 2 - 1921 ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Jan 1st, 1921.

that I last saw h[illegible] alive on Jan 31st, 1921.

and that death occurred, on the date stated above, at 6:12 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jefferies Dunck M. D.

, 19 (Address) 2846 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynn, Massachusetts	Feby 3/21.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Fold in only if important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050426 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. PUBLIC HEALTH SERVICE HOSPITAL #56 FORT MCHENRY BALTIMORE MD. REGISTERED NO. 1050

CITY OF BALTIMORE: (No. 24 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucian Watkins

(a) RESIDENCE. No. U.S. PUBLIC HEALTH SERVICE HOSPITAL #56 ST.: WARD:
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----- --

6 DATE OF BIRTH (month, day, and year) -----

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) --------

(c) Name of employer -------

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosebrock Registrar
(Address) Fort McHenry Baltimore Md.

15 FEB 2 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to February 1, 1921, that I last saw him alive on February 1, 1921, and that death occurred, on the date stated above, at 12:25 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus, & Bright's disease chronic.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings.

(Signed) Thomas R. Payne, M. D.

, 19 (Address) U.S. PHS. HOSP. #56 FT McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL Feb 4 1921

20 UNDERTAKER J. Hunter & Bro ADDRESS 124 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

050427 HEALTH DEPARTMENT—CITY OF BALTIMORE 050427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1039 William St. ST.: 24 WARD) 79 REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Pipkin.

(Residence in Baltimore: No. 1939 William St. St.; 37 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, November 16th. 1879, (Month) (Day) / (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 2 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Frank Pipkin.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Caroline Stanka.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida R. Pipkin. (wife)

(Address) 1039 William St.

15- FEB 2 - 1921 Filed ....., 191.... ROBERT J. LANTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31st. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Jan 31, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity	Feb 3 '21
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave

(1) Make return in PLAIN TERMS. PHYSICIANS should state DISEASES OF OCCUPATIONS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50428 — 120 — D 50428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 W Franklin St - ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Stein

(a) RESIDENCE. No. 906 W Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Edward Stein

6 DATE OF BIRTH (month, day, and year) Jan 9-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinand Liebich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Simon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Meister
(Address) 906 W Franklin

15 Filed FEB 2 - 1921 ROBERT J. BRUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 19 21

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921, to Jan. 31, 1921, that I last saw h[illegible] alive on Jan 31, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L Engelhart, M. D.

2/1, 1921 (Address) 1729 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Feb 3 19 21

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 050429

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 N Caroline ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kirk Braun

(a) RESIDENCE. NO. 1813 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Martha L Braun

6 DATE OF BIRTH (month, day, and year): Jan 4/1845

7 AGE — Years: 76 — Months: — Days: 27

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 1868

(b) General nature of industry, business, or establishment in which employed (or employer): School Teacher

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cent Co Md

PARENTS

10 NAME OF FATHER: Clemson Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Eliza Clemson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant (Address): Mrs. C. Clemson Braun 1223 Jah Road

15 Filed FEB 2 - 1921 ROBERT J. CRAIG Registrar

Burial Permit Given

Johnson 1307 N Charles St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Jan. 31, 1921, that I last saw him alive on Jan. 31, 1921, and that death occurred, on the date stated above, at 4 1/30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. F. Robinson, M. D.

2/1. 1921 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Cemetery Harford Ave

DATE OF BURIAL: Feb 3 - 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E. North Ave.

TION is very important. See instructions on back of

Spec.—5-19-13—M. & T.—500 Bks.

D50430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50430

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Rice St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Davenport

(Residence in Baltimore: No. 1013 Rice St.: ....yrs., 7 mos. ....ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... January 30, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Davenport

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Elmore Goldsboro

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Davenport

(Address) 1013 Rice St

15- Filed FEB 2 - 1921 191.... ROBERT B. BEAUTER Registrar. Burial Permit No. 9183

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 30th 1921, to Jan 31st 1921, that I saw h.. alive on January 30 1921, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ....yrs. ....mos. 7 ....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Jan 31st, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb 2.., 1921

20-UNDERTAKER James H Dennis

ADDRESS 1303 Pennsylvania Ave

IMPORTANT: See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150431 — 170 — 150431

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1719 Division St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel A. Charnes

(Residence in Baltimore: No. 1719 Division St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widow

6-DATE OF BIRTH, ... (Month) Unknown, (Day) ....., 1835 (Year)

7-AGE, 86 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, not given

11-BIRTHPLACE OF FATHER (State or Country), not given

12-MAIDEN NAME OF MOTHER not given

13-BIRTHPLACE OF MOTHER (State or Country), not given

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry A. Charnes

(Address) 1719 Division St.

15- FEB 2 - 1921

Filed ....., 191... EDWARD F. KRAUTER

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 28 1921, to Jan 31 1921, that I saw h[er] alive on Jan 31 1921, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) M. H. Smith

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Short M. D.

Jan 31, 1921. (Address) 18 E Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 3, 1921

20-UNDERTAKER	ADDRESS
James H Dennis	1303 Pennsylvania Ave

important. See instructions on back of certificate.

050432 HEALTH DEPARTMENT—CITY OF BALTIMORE 050432

CERTIFICATE OF DEATH. 175-003

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Thorsalon Thornton

(Residence in Baltimore: No. —— St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 29 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer 04

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida Godsall

(Address) 246 Bowers Court

15- FEB 3 - 1921 ROBERT A. CHAJTER
Filed ..... 192.. REGISTRAR OF VITAL STATISTICS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest,
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest,
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage brain (subdural) Blunt by Injury

(Duration) Hr. 3 yrs. Accidental ds.

CONTRIBUTORY (Secondary) Concussion brain

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore

19-PLACE OF BURIAL OR REMOVAL, Ft Avenue Cem

DATE OF BURIAL, Feb 2, 1921

20-UNDERTAKER Wm R A Elliott

ADDRESS 1725 Ashland Av

7.6570

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Exact statement of PLACE OF DEATH is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Talbot Av ST.; 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Cook.

(Residence in Baltimore: No. 3120 Talbot Av St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 10, 1877
(Month) (Day) (Year)

7-AGE, 28 yrs. 10 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Henry Cook.

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Fanny Kelly.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cooper

(Address) 3120 Talbot-Av

15- ROBERT J. KRAUTER

Filed FEB 2 1921, 191.. Special Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1921, to Jan 30 1921, that I saw h- alive on Jan 30 1921, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Morgan M.D. M. D.

Jan 31st, 1921. (Address) 401 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery — DATE OF BURIAL, Feb 2, 1921

20-UNDERTAKER Wm Robert A Elliott — ADDRESS 1725 Ashland Av

(1) Fill out all items if possible. Please see instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

134 D50434

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Grimes

(a) RESIDENCE. No. 715 Sterling ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of – John Grimes

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant R. L. Johnston M.D.
(Address) Johns Hopkins Hospital Balto. Md

15 Filed FEB 2 – 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17

I HEREBY CERTIFY, ... attended deceased from Jan 31, 1921, to Jan 31, 1921, that I last saw her alive on Jan 31, 1921, and that death occurred, on the date stated above, at 1021 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured extra-uterine pregnancy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

Operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 31, 1921

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) E. L. Stone, M. D.

2/1/1921 (Address) Johns Hopkins Hosp. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester Town Md	Feb 3 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050435 HEALTH DEPARTMENT—CITY OF BALTIMORE C 50435

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A Kelly Hospital; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie L. Miller

(Residence in Baltimore: No. Howard A Kelly Hospital St.; yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Gerardstown West Va.

PARENTS.

10-NAME OF FATHER, William S. Miller

11-BIRTHPLACE OF FATHER (State or Country) West Va.

12-MAIDEN NAME OF MOTHER Isabella W. McKown

13-BIRTHPLACE OF MOTHER (State or Country), West Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. P. Miller

(Address) Cumberland Md.

15- ROBERT J. KRAUTER

FEB 2 1921 ..... 191.... Registrar. Local Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Feby (Day) 1 (Year) 1921

17- I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Feby 1 1921, that I saw her alive on Feby 1 1921, and that death occurred, on the date stated above, at 6.25 p.m.

The CAUSE OF DEATH* was as follows:

Coat of uterine clot

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myxo fibroma Saecum

..... (Duration) 10 yrs. ....mos. ....ds.

(Signed) Dudley A Robertt M. D.

Feby 1..., 1921 (Address) 1418 Eutaw Pla

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. none 2/1/21

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence Gerardstown W Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Gerardstown W. Va	Feby 3, 1921
20-UNDERTAKER	ADDRESS
Chas. G. Black & Sons	W. Northam

Superintendent: See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050436 1050436

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 257 East ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Esabella

(Residence in Baltimore: No. 257 East St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 19 (Day), 1921 (Year)

7-AGE, ...yrs. 15 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Giuseppe Esabella

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Josephine Corrado

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giuseppe Esabella

(Address) 257 East 5th

15- FEB 2 1921 Filed ..., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1921, to Feb 2 1921, that I saw h[illegible] alive on Feb 1 1921, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Primary Bronchio Pneumonia

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. ...ds.

(Signed) Luigi L. Di Stefano M. D.

Feb 2, 1921 (Address) 407 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cem

DATE OF BURIAL, 2/4/21, 191...

20-UNDERTAKER Geo J. Rutt

ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050437 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050437

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olaf Olsen

(a) RESIDENCE. No. 1825 Hope St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ 2-yr. mos. ds. How long in U. S., if of foreign birth? ~~Unknown~~ 8 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Olaf Jonson Olsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Hanna Rudd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Hospital Records (Address) M.C.H.

15 Filed FEB 2 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1921, to Jan. 31, 1921, that I last saw him alive on Jan. 31, 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum

(Signed) L. J. Rigney, M. D.

1-31-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 2/3/21

20 UNDERTAKER George T. Keith — ADDRESS 735 Hanford

THON is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

Humble

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50438 D50438

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1128 Peach alley St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Humble

(Residence in Baltimore: No. 1128 Peach alley St.; 18 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	married

6-DATE OF BIRTH, ... Sept. (Month) 1 (Day) 187[illegible] (Year)

7-AGE, 44 yrs. 9 mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 074

9-BIRTHPLACE, (State or Country), Cumberland Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Hannah Humble

(Address)..... 2648 15th St. N.W. Washington D.C.

15-Filed FEB 2 - 1921 191.... ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 3 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1920, to June 3, 1921, that I saw h[illegible] alive on Jan. 30 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Exposure)

..... (Duration) ..... yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

June 3, 1921 (Address) 703 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	Feb. 3..., 1921
20-UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Montg St

Important. See instructions on back of certificate.

D50439 HEALTH DEPARTMENT—CITY OF BALTIMORE D50439

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 Vincent ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Collins

(Residence in Baltimore: No. 1606 Vincent St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, November, 1867
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 0.70

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Toby Collins

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Kitty Jones

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virgie Hafford

(Address) 608 East St.

15- FEB 2 - 1921 ROBERT E KRAUTER
Filed ..., 191... Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry) Coroner and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy (Coroner) M. D.

Jan 31 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Feb. 2, 1921

20-UNDERTAKER Edw. Ringgold — ADDRESS 1463 Carey St

IMPORTANT.—Physicians should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Rpsc.—6-9-19—B. P. Co.—1000 Bks.

050440 HEALTH DEPARTMENT—CITY OF BALTIMORE 050440

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James G. Legg

(a) RESIDENCE. No. 317 Forest Road ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mrs Jas. G. Legg

6 DATE OF BIRTH (month, day, and year) March 22 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	8	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Grain dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John G. Legg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Belle Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Legg
(Address) Roland Park

15 Filed FEB 2 - 1921 19 ROBERT B. KRAMER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 — 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Feb. 1st, 1921, that I last saw him alive on Feb. 1 —, 1921, and that death occurred, on the date stated above, at 1.35 p.m.

The CAUSE OF DEATH* was as follows:

Respiratory failure
Toxemia (Exhaus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical —

(Signed) A. H. Zimmerman, M. D.

2/1 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 3 1921

20 UNDERTAKER J. Perkins Bro Inc

ADDRESS Greenmount Ave Collington

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

50441 HEALTH DEPARTMENT—CITY OF BALTIMORE 50441

CERTIFICATE OF DEATH. 80

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3800 Forest Park Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Thomas Starr

(a) RESIDENCE. NO. 3800 Forest Park ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) ~~WIFE~~ of Widowed

6 DATE OF BIRTH (month, day, and year) May 11 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63.	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - pw

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER B. F Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary E Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Ann E Starr
(Address) 3800 Forest Park Ave

15 Filed FEB2-1921 19 ROBERT P KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan ..., 1920, to Feb 1 1921, that I last saw him alive on Jan 31 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Saw him in attack

(Signed) A. C. Smith, M. D.

Feb 3 1921 (Address) 4309 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cemetery	Feb 3rd 1921
20 UNDERTAKER	ADDRESS
J. D. Jenkins & Son Co	Orchard & Mt Holly Sts

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA... should state

Spec.—6-9-19—H. P. Co.—1000 Blks.

A050442

HEALTH DEPARTMENT—CITY OF BALTIMORE

A050442

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 St Paul ST.: 11 WARD)

2-FULL NAME Emily Hayward Garnett

(a) RESIDENCE. No. 929 St Paul ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Edgar M. Garnett

6 DATE OF BIRTH (month, day, and year) 1829-1-3

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady. Od

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Thomas Hayward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Margaret Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Allen Garnett Chisolm

(Address) 219 W. Monument

FEB 2 - 1921

SOLOMON I KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Jan 2, 1921, that I last saw h.e alive on Jan 1, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Lemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Visual Exp -

(Signed) Karl Kaufman, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Feb 3d 1921
20 UNDERTAKER	ADDRESS
A. Henderson Sons Co	Eutaw & Fayette Sts

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50443 ✓ D 50443

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Hanley

(a) RESIDENCE. No. Intown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Unk

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65? Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14
Informant
(Address)

FEB 2 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/11 1921

17
I HEREBY CERTIFY, That I attended deceased from 12/25 1920, to 1/11 1921,
that I last saw h alive on 1/11 1921,
and that death occurred, on the date stated above, at 6.30 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) yrs. mos. 2 wks

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lyman D. Roberts, M. D.

1/21, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 2 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

WM. F. WOODALL

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wahlstein

D 50444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50444

CERTIFICATE OF DEATH.

X 113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hyde Ave; ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wahlstein

(a) RESIDENCE. No. 109 Bay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/1/54

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Chas. Wahlstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant.....
(Address) JOHNS HOPKINS HOSPITAL

15 Date Received FEB 2 - 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/24, 1921, to 1/24, 1921, that I last saw h alive on 1/24, 1921, and that death occurred, on the date stated above, at 6.40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion of knee

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. A. Reily Jr., M. D.

1-7, 1921 (Address) Wyndhurst.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 2 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

IMPORTANT is very important. See instructions on back of certificates.

Brandau

Spec.—6-9-19—H. P. Co.—1000 Bks.

050445 HEALTH DEPARTMENT—CITY OF BALTIMORE 050445

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 Dolphin St.: 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Brandau

(a) RESIDENCE. No. 713 Dolphin St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Laura M. Brandau

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Toy Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rev Geo H. Brandau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Vogt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura M. Brandau (Address) 713 Dolphin St

15 Filed FEB 2 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit 01008

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to Jan 31, 1921, that I last saw h[illegible] alive on Jan 31, 1921, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Microscopic

(Signed) Geo W Lemmert, M. D.

Feb 1, 1921 (Address) 800 Harlem Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Greenmount — DATE OF BURIAL Feb. 3 1921

20 UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Av

TION is very important. See instructions on b[illegible] ...ould be ...ccupa... ...ertificates. Exact statement of OCCUPA... ...may be properly classified. ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50446 HEALTH DEPARTMENT—CITY OF BALTIMORE D50446

CERTIFICATE OF DEATH. +84

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Keenan

(a) RESIDENCE. No. Brunswick Md ST., WARD. Brunswick Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June. 16 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brunswick Maryland.

PARENTS

10 NAME OF FATHER Jacob Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Jessie Powers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hash. Co. Md

14 Informant (Address) Jacob Keenan Brunswick Md.

15 Filed FEB 2 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from January 18 1921, to Feb. 2, 1921, that I last saw her alive on Feb. 2, 1921, and that death occurred, on the date stated above, at 7.05 a.m.

The CAUSE OF DEATH* was as follows:

Cavernous Lymphangioma

General Septicemia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 1 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Cyrus J. Stonier, M. D.

2/2, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brunswick Md.	Feb 2" 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1093 W. Balto St.

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA... should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

J. C. Harrell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50447

CERTIFICATE OF DEATH.

D 50447

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3927 Foster Ave ST. 26 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Clarke Sr.

(a) RESIDENCE. No. 3927 Foster Ave ST. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Elizabeth Clark.

6 DATE OF BIRTH (month, day, and year) Aug 20th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder.

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10 NAME OF FATHER Robert Clarke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Robert Clarke. (Address) 3927 Foster ave.

15 Filed FEB 2 - 1921, 19 ROBERT P. KRAUTH Registrar

Burial Permit 21078

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/29/21, 19..., to 1/30/21, 19..., that I last saw him alive on 1/30/21, 19..., and that death occurred, on the date stated above, at 9 1/2 p. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. McGarrell M. D.

(Address) 633-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Feb 3rd 1921

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S Wolfe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L050448

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050448

CERTIFICATE OF DEATH.

63

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 N. Gay ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Sutherland

(a) RESIDENCE. No. 1109 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Sutherland

6 DATE OF BIRTH (month, day, and year) July 5th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	6	27	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nelson Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Benjamin E Sutherland

(Address) 1109 N Gay st

FEB 2 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 1918 to Feb. 1 1921

that I last saw h[illegible] alive on Jan. 31 1921

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis Hood

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Benj. P. Hayden M. D.

2/2. 1921 (Address) 1216 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cemetery	Feby 4th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Mona

TION is very important. See instructions on back of certificates.

050449 HEALTH DEPARTMENT—CITY OF BALTIMORE 050449

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 511 S. Pratt St ST.: 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hrunyka Adamska

(Residence in Baltimore: No. 805 Dallas St.; 11 yrs., mos. ds.)

PLEASE WRITE PLAINLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, July (Month) 20 (Day) 1903 (Year)

7-AGE, 17 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Frank Adamska

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Eva Trush

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Adamska

(Address) 805 S Dallas

15- SOBEL & KRAUTER

Filed FEB 2 - 1921 191 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) .....find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

PATENT
Pneumonia
Measurement to Left Feb. 3 - 8 50 A.M.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) W H Riley M. D.
(Coroner.)

Feb 2, 1921 (Address) 659 Ry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem.,	Feby 4", 1921
20-UNDERTAKER	ADDRESS
M. J. Sadowski	705 N. Ann

Spec.—6-9-19—H. P. Co.—1000 Bks.

050450

HEALTH DEPARTMENT—CITY OF BALTIMORE

050450

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 E Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Ehrlinger

(a) RESIDENCE. No. 2408 E Federal ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 1

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) W. Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Fr. Ehrlinger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 85 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) 2408 E Federal St.

FEB 2 - 1921

[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to Feb 1, 1921, that I last saw h[illegible] alive on Feb 1, 1921, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Obliterative Endarteritis

Arterial sclerosis.

Leg ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. A. G. Rohde, M. D.

Feb 1 1921 (Address) 908 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: 2-3rd 1921

20 UNDERTAKER: Mrs. Chas. A. G. Rohde ADDRESS: 600 N Arlington Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50451

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1630 E Preston ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Charlton

(a) RESIDENCE. No. 1630 E Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Charlton

6 DATE OF BIRTH (month, day, and year) Sept 7. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Maggie Kelly

(Address) 1630 E Preston

15 Filed ....., 19.... Registrar

FEB 2-1921 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Feb 2, 1921, that I last saw h.. alive on Feb 1, 1921, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Arsone Interstial Nefritis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Mitral Valve Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient Went to bed 14 days before death at Penitentiary Home 4 days before death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis &c

(Signed) J. A. Shelley M.D., M. D.

2/2, 1921 (Address) 3849 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feby 3 1921

20 UNDERTAKER: J Hervig & Co

ADDRESS: 200 Eutaw

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement
OCCUPA-
s should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50452

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Brown

(a) RESIDENCE. No. 1306 Mc Henry St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Polly E. Brown

6 DATE OF BIRTH (month, day, and year) Dec. 18-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Henry Brent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co Md.

12 MAIDEN NAME OF MOTHER Frances —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co Md

14 Informant Polly E. Brown

(Address) 1306 Mc Henry St.

15 Filed FEB 2-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1921

17

I HEREBY CERTIFY, That I attended deceased, from Jan. 30, 1921, to Jan 31, 1921, that I last saw him alive on Jan. 31, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Double Lobar Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Slater's Cem. Balto. Co	Feb. 3 1921
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	363 Hall Pl

IMPORTANT is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D. 50453 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50453

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Carter

(Residence in Baltimore: No. 1014 Argyle Ave St.; 62 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, March 6, (Month) (Day) 1859 (Year)

7-AGE,	If LESS than 1 day,
68 yrs. 10 mos. 25 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter 670
(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

9-BIRTHPLACE, (State or Country), Liberty Md

PARENTS.

10-NAME OF FATHER, Wesley Carter

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hettie Waters

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Carter

(Address) 1014 Argyle Ave

15-

Dec 9 1921 Robert P. Harrison, Registrar.

FEB 2 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1st, (Month) (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1921, to Nov 1st 1921, that I saw him alive on Jan 21 1921, and that death occurred, on the date stated above, at 5:57 m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease (Duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Senile Bronchitis and Pulmonary Congestion (Duration) — yrs. 1 mos. — ds.

(Signed) Edward E. Mackenzie M. D.

Nov 1st, 1921. (Address) 1334 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Feb 1, 1921.
20-UNDERTAKER Samuel Hemsley	ADDRESS 515 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D.50454 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50454

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Amity ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen A Handy

(Residence in Baltimore: No. 204 N Amity St.; 26 yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 10 (Day), 1894 (Year)

7-AGE, 26 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Napoleon B. Triggs

11-BIRTHPLACE OF FATHER (State or Country), Miss. Dixie

12-MAIDEN NAME OF MOTHER Caroline R. Kay

13-BIRTHPLACE OF MOTHER (State or Country), Carrol County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Caroline Triggs

(Address) 751 George St.

15-

Filed....., 191.... Robert P. Harrison, Registrar.

2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 20 1921, to Jany 31 1921, that I saw her alive on Jany 30 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. Cordell M. D.

Feb 1, 1921 (Address) 1319 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Feb 3, 1921

20-UNDERTAKER, Samuel Hensley ADDRESS 778 N Eddad

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D. 50455 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50455

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 703 W Lafayette Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Matthews

(Residence in Baltimore: No. 703 W Lafayette Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... July (Month) 20 (Day), 1919 (Year)

7-AGE, 1 yrs. 6 mos. 21 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Leon Mathews

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Saunders

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Mathews

(Address) 703 W. Lafayette Ave

15- FEB 2 - 1921 Robert P. Harrison, Registrar.

Filed ....., 191.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 1st (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1921, to Feb 1st 1921, that I saw her alive on Feb 1st 1921. and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH* was as follows:

(See Bronchitis)

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John A Stewart M. D.

2-2-21, 191... (Address) 703 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem — DATE OF BURIAL, Feb 3, 1921

20-UNDERTAKER Samuel Kemsley — ADDRESS 518 N Bond St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D.50456

1920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1124 Brevard St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Feeley

(a) RESIDENCE. NO. 1124 Brevard St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Feeley

6 DATE OF BIRTH (month, day, and year) Apr., 9th. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) -------

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sharkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John V. Feeley (Address) 1124 Brevard St.

15 Filed Robert P. Harrison, Registrar

3-2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31st. 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Jan 31, 1921, that I last saw her alive on Jan 31, 1921, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

over 3 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert Silverstein, M. D.

19 (Address) 134 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 2/3" 21

20 UNDERTAKER: C.F.Evans & Son-118 W.MtRoyal Ave. ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50457 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50457

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N Duncan ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston Shields

(Residence in Baltimore: No. 508 N Duncan St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Le

5-~~SINGLE~~ MARRIED, WIDOWED, OR ~~DIVORCED~~, (Write the word.)

6-DATE OF BIRTH, Don't know, 1863 (Month) (Day) (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Known

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Nichols

(Address) 508 N. Duncan St.

15-

Filed ....., 191.....

FEB 2 - 1921 Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH January 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 31 1921, that I saw h.. alive on Jan 30 1921, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Leonea

..... (Duration) 1 yrs. ..... mos. 1 ds.

(Signed) W. A. Cogle M. D.

2/2/21, 191... (Address) 706 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Asbury Cemetery	2, 1921
20-UNDERTAKER John. W. Henderson	ADDRESS 1512 E Monument St

Fill out all the items. Read instructions on back of certificate. Be sure statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Blks.

20.50458 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50458

CERTIFICATE OF DEATH. 153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 N. Dallas ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Payne

(a) RESIDENCE. No. 17 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. - mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Howard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Adelaide Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Adelaide Payne
(Address) 17 N. Dallas

15 Filed FEB 2-1921 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to Feb 1, 1921, that I last saw h... alive on June 31, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute -

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Neglect of Mother

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2-7-21 (Address) 317-18 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Feb 3 192

20 UNDERTAKER: John W Henderson — ADDRESS 150 E Monum

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Hummel

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50459 HEALTH DEPARTMENT—CITY OF BALTIMORE D50459

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Jackson ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryland Hummel

(a) RESIDENCE. NO. 1527 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Des Moines Iowa

PARENTS

10 NAME OF FATHER Guy Hummel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mable League

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mechanicks Burg Ohio

14 Informant Guy Hummel
(Address) 1527 Jackson st

15 Filed FEB 3 - 1921 ROBERT I. LAUTER Registrar

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 2 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2nd 10 A.M. 1921, to Feb 2 7 P.M. 1921, that I last saw h alive on Feb 2nd 1921, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Tonsilar diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart-failure L
Empyema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. X. Shepard, M. D.

2/2/1921 (Address) 423 E. Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedarhill cem	FEB 3RD 1921
20 UNDERTAKER Roberts Brookeaven	ADDRESS CALHOUN HOLLINS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050460

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050460

CERTIFICATE OF DEATH.

55-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S Bond ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Szymanski

(a) RESIDENCE. No. 211 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 31 May 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) American Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Szczepanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Szymanski (Address) 211 S Bond St

15 FEB 3 - 1921

16 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1921, to Feb 1st, 1921, that I last saw him alive on Feb. 1st, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & symptoms & symptoms

(Signed) A Fries, M. D.

Feb 7, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 4 1921
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

See affadarit over Sarah McCarthy. Daniels

650461 HEALTH DEPARTMENT—CITY OF BALTIMORE 650461

CERTIFICATE OF DEATH.

REGISTERED NO. C 56

1-PLACE OF DEATH 345

CITY OF BALTIMORE (No. ~~351~~ 345 Canton Land ST.: 4 WARD) (Daniels)

2-FULL NAME Sarah McCuskey

(Residence in Baltimore: No. ~~351~~ 345 Canton Land St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March 20th, 1883 (Month) (Day) (Year)

7-AGE, 37 (?) yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Cook

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Andrew McCuskey.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Catherine Connel.

13-BIRTHPLACE OF MOTHER (State or Country), Dublin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McCuskey

(Address) Fulton Catonsville

15- ROBERT E KRAUTER

Filed FEB 3 - 1921 191 Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 30 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cause of death as shown by Autopsy = Not Known — Chem. Anal. ~~at~~ analysis reported in 10 days. Sufficient Cause —

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Feb 7 1921 (Address) 1029 Key

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Wood Lawn Cemetery. DATE OF BURIAL, Feb 2th, 1921

20-UNDERTAKER George F. Ruth ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important., See instructions on back of certificate.

M Death. & Chemical analyses made of Stomach & brain - Probably Acute Alcoholism

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death) 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death.

Abortion,	*Hemorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

D. 50461 D-50

Baltimore, Md.

April 9th, 1921

I, Patrick E. Daniels, hereby acknowledge Sarah McKuskey to be my legally wedded wife; I having been married by Rev. V. K. Bar on September 30th, 1896 at St. Joseph's Monastery.

Witness my hand and seal this 9th, day of April 1921.

Patrick E. Daniels

Witness Emily [illegible]

Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50462

CERTIFICATE OF DEATH.

REGISTERED No. C 15 - 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 Woodbrook Av St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian England

(Residence in Baltimore: No. 2433 Woodbrook Av St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, ... Nov ... (Month) ... — (Day) ... 1835. (Year)

7-AGE,	If LESS than 1 day,
85 yrs. 2 mos. ... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer) ... Maker of shoes

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Ulrich

(Address) 2433 Woodbrook Av.

15- ROBERT E KRAUTER

Filed FEB 3 - 1921 191 ... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1st, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 28 1921, to Jan 1st 1921, that I saw h[illegible] alive on Jan 1st 1921, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy ... (Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema ... (Duration) ... yrs. ... mos. One ds.

(Signed) Edward Gilbach ... M. D.

Jan 2, 1921. (Address) 133 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Feby 4, 1921.
20-UNDERTAKER Harry W. Eblen	ADDRESS 1944 W. North Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

50463

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 50463

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Fleet St. ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. E. Meyers

(a) RESIDENCE. NO. 1718 Fleet St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Aug. 17-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	-	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None oo

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary L. Shenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co., Md.

14 Informant John H. Meyers
(Address) 1718 Fleet St.

15 Filed FEB 3 - 1921 19 ROBERT T. CRANTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28th, 1921, to Feb 2nd, 1921, that I last saw h[illegible] alive on " " 1921, and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis (Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wenner, M. D.

2-7-1921 (Address) 308 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Feb 4 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L050464

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050464

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1404 Harford Ave ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie M. Wolf

(a) RESIDENCE. No. 1404 Harford Av ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Leonard Wolf

6 DATE OF BIRTH (month, day, and year) November 17 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Wieland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant M. Leonard Wolf
(Address) 1404 Harford Ave.

15 Filed FEB 3 - 1921 19 ROBERT E KRAUTER Registrar Capital Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1921, to Feby 2, 1921, that I last saw her alive on Feby 2, 1921, and that death occurred, on the date stated above, at 12100 m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. L. Hornstein, M. D.

2/2, 1921 (Address) 733 Asquith St

*State the Disease Causing Death, as in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL February 5th 1921

20 UNDERTAKER Henry Horsch Sons — ADDRESS 130 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 W 18th Sts ST.; 25 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy R Logan

(Residence in Baltimore: No. 1500 W 18th Sts St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) S

6-DATE OF BIRTH, 2 (Month) 2 (Day) 1921 (Year)

7-AGE, — yrs. ....mos. ....ds. If LESS than 1 day, 8 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles R Logan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rose Reckess

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas R Logan

(Address) 12 West 18th St

15- Filed FEB 3 - 1921, 191.... ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/1 1921 to 2/2 1921, that I saw h im alive on 2/2/21 191..., and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pressure on umbilical cord

(Duration) ....yrs. ....mos. ....ds.

(Signed) J M McGuill M. D.

2/3, 191.. (Address) 633 S 39

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bachman Cemetery

DATE OF BURIAL, 2-3....., 1921

20-UNDERTAKER J J Moran

ADDRESS 300 E Baltimore

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50466

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 33 S. Bunley St.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William b. Barnes

(a) RESIDENCE. No. 33 S. Bunley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 57 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 29-1921

7 AGE — Years: — Months: — Days: 4 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm. A. Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary Lampley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wm. A. Barnes (Address) 33 S. Bunley St

15 Filed FEB 3 - 1921 BOBER & KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/2/21

17 I HEREBY CERTIFY, That I attended deceased from 1/29/21, 19..., to 2/2/21, 19..., that I last saw him alive on 2/2/21, 19..., and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ...yrs, ...mos. 4 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ...yrs. ...mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) T. W. Hurmant, M. D.

3/21 (Address) 2919 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Inf Oliver Cemetery

DATE OF BURIAL: 2 3 19

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E Balto St.

TION is very important. See instructions on back of certificates.

...may be properly classified. Exact statement of OCCUPA...

D50467 HEALTH DEPARTMENT—CITY OF BALTIMORE D50467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2855 W. Lafayette Ave 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcellus G. Dyson.

(Residence in Baltimore: No. 2855 W. Lafayette ave St.; yrs., mos. ds.)

64

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July 24, 1857
(Month) (Day) (Year)

7-AGE, 58 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Piano 066

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Alexander Dyson.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dout Knox

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary D. Dyson

(Address) 2855 W. Lafayette Ave

15- FEB 3 - 1921 ROBERT F. KRAUTH

Filed ....., 191.... Registrar

Burial Form

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (5 minutes)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

Feb 2, 1921 (Address) 2802 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn

DATE OF BURIAL, Feb 3, 1921

20-UNDERTAKER Lowbook

ADDRESS 502 E. Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2

L050468 HEALTH DEPARTMENT—CITY OF BALTIMORE L050468

CERTIFICATE OF DEATH.

79

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 40 E. York St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph R. Tregoe.

(Residence in Baltimore: No. 40 E. York St.

78---------

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE, 73 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Police Report.

(Address) ..... JOHNS HOPKINS HOSPITAL

15- ROBERT A KRAUTER

Filed FEB 3 - 1921 191 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 23rd. 1921. ....., 191 ...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)
inquiry ..... find that said deceased came to ..... his ..... death
on the day stated above.
The CAUSE OF DEATH* was as follows:

..... Organic disease of the heart. .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Otto M. Reinhardt ..... M. D.
(Coroner.)

Feb 1st 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, FEB 8 1921

20-UNDERTAKER Commissioner Health,

ADDRESS

Wm. B. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. ACE should be stated properly classified. Exact statement of OCCUPATION is very may be

Poppe

1050469 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050469

CERTIFICATE OF DEATH.

79

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 786 E. 28 St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frederick Poppe

(Residence in Baltimore: No. 786 E. 28 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 34 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE. (State or Country), Penn

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- FEB 3 - 1921 Filed ..... 191.....

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Mason Hundley M. D.
(Coroner.)

1-25 1921 (Address) 4 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	FEB 3 1921
20-UNDERTAKER Commissioner Health,	ADDRESS

Dr. Wm. S. WOODALL.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050470

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050470

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 Lorman ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Simms

(a) RESIDENCE. No. 1842 Lorman ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. Simms (deceased)

6 DATE OF BIRTH (month, day, and year): July 1840

7 AGE — Years: 81 — Months: 7 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jake Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Maggie Harvey 1842 Lorman St

15 FEB 3 - 1921 — Registrar — Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1921, to Feb. 1, 1921, that I last saw h[illegible] alive on Feb. 1, 1921, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Gastritis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? 1842 Lorman

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.

2/2 1921 (Address) 1507 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 4th 21

20 UNDERTAKER: Clarence E. Orgill — ADDRESS: 1426 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bowen

D50471 HEALTH DEPARTMENT—CITY OF BALTIMORE D50471

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 414 S Regester ST. V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Bowen

(Residence in Baltimore: No. 414 S Regester St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 2, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 16 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, William Bowen

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Rose Lobby

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Bowen

(Address) 414 S Regester St

15 FEB 3 - 1921

Filed....., 191... ROBERT J. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Schwartz M. D.
(Coroner.)

Feb 2, 1921 (Address) 204 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Shwartz's Cem. DATE OF BURIAL, Feb 4, 1921.

20-UNDERTAKER W. F. Sadowski ADDRESS 908 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050472

HEALTH DEPARTMENT—CITY OF BALTIMORE

050472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSPITAL #56 REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. ST.: 24 WARD 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM ROSTON

(a) RESIDENCE. No. US. PUBLIC HEALTH SERVICE HOSPITAL #56 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 40

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Kranbuhl Registrar
(Address) Fort McHenry Baltimore Md.

15 Filed FEB 3 - 1921 ROBERT J. KRAUSS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1921, to Feb. 2, 1921.
that I last saw him alive on Feb. 2, 1921.
and that death occurred, on the date stated above, at 12'20 p.m.
The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary, far advance & active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ----

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Laboratory report

(Signed) Sumner R. Payne. M. D.

2-2-1921 (Address) US. PHS. HOSP. #56 Ft McHenry Md. senior surg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 3. 1921
20 UNDERTAKER S. Turner & Bro	ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificates.
at it may be properly classified. Exact statement of OCCUPA-
PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

Bitz

D50473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 Mt Holly St.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J Bitz

(Residence in Baltimore: No. 2145 Mt Holly St.; 39 yrs., 10 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 9 (Day), 1881 (Year)

7-AGE,	If LESS than 1 day,
39 yrs. 10 mos. 22 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manager-Oil
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Varnish Co

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, William J. Bitz (deceased)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Emma A Müller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Franklin J. Bitz

(Address) 3020 Belmont Ave

15- FEB 3 - 1921 SORRELL & ABAUTER

Filed....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Feb 1 1921, that I saw him alive on Feb 1 1921, and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ....yrs....mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) ....yrs....mos. 3 ds.

(Signed) W. S. Niblett M. D.

Feb 1, 1921. (Address) 2220 Garrison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Feby 4, 1921

20-UNDERTAKER	ADDRESS
Geo. A. Gerlig	2001 W Baltimore St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050474 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050474

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Ellamont ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ross A Bolton

(a) RESIDENCE. No. 1710 Ellamont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida L Bolton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel A Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliz L. Blackler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank C Bolton
(Address) 1206 St Paul St.

15 Filed FEB 3 — 1921 [illegible] A KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 2, 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 10 — 1920, to Feb 2d, 1921, that I last saw h[illegible] alive on Jan Feb 1st, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach (Pyloric End and involving Duodenum)
unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Roberts Bunk M. D.

2/3, 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemy	Feby 4 1921

20 UNDERTAKER J O Mitchell ADDRESS 1201 W Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50475 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50475

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH South Baltimore General Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gaffney

(a) RESIDENCE. No. 517 F ST. Sparrows Pt

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Daniel Richard Gaffney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret C. Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant D. P. Gaffney

(Address) Sparrows Point

15 Filed FEB 3 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1921, to Feb. 2, 1921, that I last saw her alive on " " , 1921, and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows: Spontaneous Hemorrhage in newborn.

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L. Jolson, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 3 1921
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Sons	Fullerton Md

TION is very important. See instructions on back of certificates. Exact st... OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D.50476 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50476

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp. St.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

H

2-FULL NAME Mrs Justina Amanda Crane.

(Residence in Baltimore: No. 1518. West Lexington St. St.; 26. yrs., 7. mos. 21. ds.)

(Residence in Baltimore: No. Bon Secours Hospital.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May, 11, (11) 1894

7-AGE, 26 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER, Louis Jacob.

11-BIRTHPLACE OF FATHER (State or Country), Baden, Germany

12-MAIDEN NAME OF MOTHER Margaret Dietrich

13-BIRTHPLACE OF MOTHER (State or Country), Baden, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Lloyd Johnson

(Address) B. S. Hospital

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

FEB 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb., 2, 1921. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 1921, to Feb. 2 1921, that I saw her alive on Feb. 2 1921, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Septic Cerebral Haemorrhage

Induced on Vomiting

as a sequel to D. T. Pneumonia (Two)

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Traumatic Pregnancy

(Duration) ...yrs. ...mos. Probably months ds.

(Signed) A. Lloyd Johnson M. D.

Feb. 2, 191. (Address) B. S. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 7 ds. In the State 26 yrs. 7 mos. 21 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 2/6, 191.

20-UNDERTAKER Gil A Finley ADDRESS Fulton & Fayette

D.50477 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50477

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 E. West St. St.; 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H.Mills.

(Residence in Baltimore: No. 1255 Battery Ave. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower

6-DATE OF BIRTH, April 29th. 1842. (Month) (Day) , 1 (Year)

7-AGE, 78 yrs. 9 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired 061
(b) General nature of industry, business, or establishment in which employed (or employer). Policeman.

9-BIRTHPLACE, (State or Country), Dorchester Co.Md.

PARENTS.

10-NAME OF FATHER. Henry Mills.

11-BIRTHPLACE OF FATHER (State or Country). Dorchester Co.Md.

12-MAIDEN NAME OF MOTHER Mary Bradshaw.

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Creighton.(cousin)

(Address) 1255 Battery Ave.

15- Filed FEB 3 1921, 191 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1st. 1921. (Month) (Day) , 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to n/a death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Thos. M. Reinhardt M. D. (Coroner.)

Feb. 1st, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	Feb. 4, 1921
20-UNDERTAKER John F. Henny	ADDRESS Light & Montgomery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50478

CERTIFICATE OF DEATH.

176

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 N. Calvert ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Myers

(Residence in Baltimore: No. 1224 N Calvert St St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED.~~ (Write the word.)

6-DATE OF BIRTH, May (Month) 15 (Day), 1 (Year)

7-AGE, 75 yrs. 2 mos. 17 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Private Detective
(b) General nature of industry, business, or establishment in which employed (or employer)..... D.D.

9-BIRTHPLACE, (State or Country), Troy N. Y.

PARENTS.

10-NAME OF FATHER, Alfred Myers

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellie F. Myers

(Address) 1224 N. Calvert St

15-

Filed JUL 23 1921, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1921, to July 12 1921, that I saw h-im alive on July 12 1921, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia. Chronic

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Enlarged Prostate retention

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) Thos. D. Magruder M. D.

July 23, 1921. (Address) 14 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, July 14, 1921

20-UNDERTAKER John F. Denny — ADDRESS 715 Light St

IMPORTANT.—PHYSICIANS should state OCCUPATION is very important. See instructions on back of certificate.

Remarks

Retention caused uremia Primary Enlarged prostate

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*c. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50479 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50479

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1101 N Vine (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. Green

(a) RESIDENCE. No. 1101 Vine St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know 1897

7 AGE: 23 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Judie Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Elmira Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Judie Green
(Address) 1102 Vine St

15 Filed FEB 3 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1921, to Feb 1, 1921, that I last saw h.....alive on Jan 31, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Norwood, M. D.

Feb 1 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 3 1921

20 UNDERTAKER: Brown & Freeland

ADDRESS 114 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.50480 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2109 N. Fulton Ave ST.; 15 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Westbury Pyles.

(a) RESIDENCE. NO. 2109 N. Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced
HUSBAND of Lilly May Pyles
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman.

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredrick Co. Maryland

PARENTS

10 NAME OF FATHER William F. Pyles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co. Maryland

12 MAIDEN NAME OF MOTHER Ruth E. Beall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co. Maryland.

14 Informant Lilly May Pyles.
(Address) 2109 N. Fulton Ave.

15 Filed B3 1921 16 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 1 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-27-1921, to 2-1-1921, that I last saw h— alive on 2-1-1921, and that death occurred, on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary analysis

(Signed) Wm F Ruggles, M. D.

, 19 (Address) 1520 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 4 1921
20 UNDERTAKER	ADDRESS
Wm J Tuckwell Sons	N & Pa Ave

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite statements, such as "Heart Failure," "Exhaustion," "Old Age," "Paralysis," "Convulsions," "Infection," "Septicemia," "Blood Poisoning," "Cancer," "Tumor," "Abscess," "Childbirth," "Accident," "Fracture," "Injuries," "Burns," "Drowning," "Asphyxia," "Suffocation," "Homicide," "Suicide," "Pneumonia," "Tuberculosis," "Meningitis," "Hemorrhage," "Uremia," "Jaundice," "Dropsy," "Debility," "Senility," "Marasmus," "Coma," "Shock," "Collapse," "Unknown," "Undetermined," are not sufficient. OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 50481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4106 Graceland Ave ST.; 15 WARD) 140

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw Bell Hunter

(Residence in Baltimore: No. 4106 Graceland Ave St.; 57 yrs., 4 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 24, 1863
(Month) (Day) (Year)

7-AGE, ~~57~~ 57 yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Marcus Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Emma Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hunter

(Address) 4106 Graceland

15-

Filed FEB 3 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Feb 2 1921, that I saw h[illegible] alive on Feb 1 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Arteriosclerosis

Stomach, Bowels, Cancer

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Jno. E. Clough M. D.

Feb 3, 1921 (Address) 701 W. Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Comm — DATE OF BURIAL, Feb 4, 191.

20-UNDERTAKER [illegible] McKnew Bro — ADDRESS North Ave

Please write clearly. Abbreviations should state words in full. Exact statements are important. See instructions on back of certificate. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50482

CERTIFICATE OF DEATH.

REGISTERED No. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 210 Clifton Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Roland Nash

(Residence in Baltimore: No. 210 Clifton Av St.; 23 yrs., 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Sing

6-DATE OF BIRTH, June 25, 1897
(Month) (Day) (Year)

7-AGE, 23 yrs. 5 mos. 5 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lineman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John F. Nash

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Julia Cleary

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia C Nash

(Address) 210 N Wolfe

15-

Filed Feb 4 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 2/21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1920, to Feb 7 1921, that I saw h-- alive on Feb 1 1921, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiosi

(Duration) yrs. mos. 2 ds.

(Signed) Edward Mendelsohn M. D.

Feb 2, 191... (Address) 24 E Lafayette Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lincoln | DATE OF BURIAL, Feb 5, 1921

20-UNDERTAKER H Weikard Jr | ADDRESS N & Pa

Important. See instructions on back of certificate. ... OCCUPATION is very ... may be properly classified. Exact state...

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50483 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50483

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 N. Patterson Park av. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Concetta Castiglia

(a) RESIDENCE. No. 1100 N. Patterson Park av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 11 mos. 7 ds. How long in U. S., If of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 27. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rosario Castiglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Sadie Fito

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Rosario Castiglia (Address) 1100 N. Patterson Park av

15 Filed FEB 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 19—, to 2-3, 1921, that I last saw h— alive on 2-3-, 1921, and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Snyder, M. D.

, 19 (Address) 1004 Fulton, av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent's Cem — DATE OF BURIAL: 2/4/20 19

20 UNDERTAKER: Geo. E. Pugh — ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should be stated EXACTLY. PHYSICIAN'S name or initials should state TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50484 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50484

CERTIFICATE OF DEATH.

92-078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5703 Milford Ave Howard Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christiana Bamback

(a) RESIDENCE. No. 5703 Milford Ave, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Bamback

6 DATE OF BIRTH (month, day, and year): 7/17/1859

7 AGE — Years: 61 — Months: 6 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Rapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Eisman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Thomas Bamback

(Address) 5703 Milford Ave

15 Filed FEB 3 1921, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1921, to Feb 2, 1921, that I last saw h[illegible] alive on Feb 1, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D

Feb 2 1921 (Address) 2687 Wheeler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb. 5 1921

20 UNDERTAKER: George J. Smith — ADDRESS: 1000 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(William R. Deaton)

D. 50485 ~~D. 54485~~ HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50485

~~145~~ 170

+ 53

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Deaton, William R.

(a) RESIDENCE. No. Morganton N. Ca. ST.,..... WARD. F

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Ellen S. Deaton

6 DATE OF BIRTH (month, day, and year) Nov 11- 877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	2	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(h) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ~~Jno~~ Deaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Eliza Rhodes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Johns Hopkins Hospital (Address) Baltimore.

15 Filed FEB 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1921, to Feb 3, 1921, that I last saw him alive on Feb 3, 1921, and that death occurred, on the date stated above, at 11 00 a.m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia

Since May 1st, 1920

(duration)

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Morganton N.C.

Did an operation precede death? No, Date of

Was there an autopsy? No. Blood examination.

What test confirmed diagnosis?

(Signed) J. R. Mason M. D.

Feb 3. 1921 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morganton N. C.	Feb. 3rd
20 UNDERTAKER	ADDRESS
J. E. Hughes & Co	Body

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

83

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.50486 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50486

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bellevue Ave (43) 26 ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Edelman

(a) RESIDENCE. No. Bellevue Ave. (43) ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Edelman

6 DATE OF BIRTH (month, day, and year): Aug 19-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Hardware Merchants

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: C. J. Edelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Gephardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): C. J. Edelman Bellevue ave city

15 Filed FEB 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1/1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1920, to Feb 1-, 1921, that I last saw him alive on Jan 31-, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 4 mos. ds.

CONTRIBUTORY (Secondary) Pr Exhaustion

(duration) yrs. mos. 2 ds.

*18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? X Ray

(Signed) G. C. Blades, M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb. 4 1921

20 UNDERTAKER: H E Stughes ADDRESS: 1st N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact State of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50487 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50487

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH 614 E. Biddle St

CITY OF BALTIMORE: (No. ..... St.: 10 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William John Conner

(a) RESIDENCE. No. 614 E Biddle St., 10 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? ~~in Baltimore~~ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S Connor

6 DATE OF BIRTH (month, day, and year) January 25 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Male nurse 48

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Richard Connors

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emma Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Conner (Address) 614 E Biddle St

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 3, 19.., to Feby 3, 1921, that I last saw him alive on Feby 3, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplectic Convulsions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

2/7/21 19 (Address) 1132 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feby 7 1921

20 UNDERTAKER ADDRESS

Wm Cook 502 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50488

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 772 W Franklin ST. 17 WARD)

2-FULL NAME Caroline J Silvestre

(a) RESIDENCE. NO. 772 W Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver Silvestre

6 DATE OF BIRTH (month, day, and year) Dec 5 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm P. Marlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Shirley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wilmer F Silvestre
(Address) 772 W Franklin St

15 Filed Feb 4 1924 Robert T. Hartbauer
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Feb 2, 1924, that I last saw h alive on Jan 21, 1924, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo W Hemmeter M. D.

. 19 (Address) 500 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 4 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 3 1924

20.50489 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50489

CERTIFICATE OF DEATH. 192

PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospital St.: 4 WARD) REGISTERED No. C ...

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Brown.

(Residence in Baltimore: No. 620 W. Saratoga St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm. Brown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Daisy Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Brown

(Address) 620 W. Saratoga St

15- FEB 8 1921 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide, gun shot

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knox Gruber M. D. (Coroner.)

2, 192.. (Address) 9 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Richmond. Va	Feb. 4, 1921.
20-UNDERTAKER William Cook	ADDRESS 532 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.50490 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50490

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1918 Granby St. 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Cunningham

(Residence in Baltimore: No. 1319 ashland ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Jan (Month) 18 (Day), 1880 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or mdn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Alexander Cunningham

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sarah E Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah R. Cunningham

(Address) 1319 ashland ave

15- Robert P. Harrison,

FEB 3 1921 (Date), 191. Burial Permit Clerk (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28 (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tapeworm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Guy Findley M. D.
(Coroner.)

Feb 3, 191 (Address) 502 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Feb 4 1921
20-UNDERTAKER	ADDRESS
Wm Cook	502 E North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050491

HEALTH DEPARTMENT—CITY OF BALTIMORE

050491

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 501 Orkney Rd (Street) Govans (27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dawson Boardyell

(a) RESIDENCE. No. 501 Orkney Rd Govans WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bennetta Boardwell

6 DATE OF BIRTH (month, day, and year) Oct 30 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Gardner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Nelson Boardwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mahony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Nelson Boardwell

(Address) 501 Orkney Rd Govans

15 Filed FEB 4 - 1921 ROBERT J. KRAUTER Registrar

Dr Duncan 5106 York Rd Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1921, to Feby 2, 1921, that I last saw him alive on Feby 2, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows: (Over)

Fractured Hip complicated by Obstruction of Bowels

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. K. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Grnd — DATE OF BURIAL: Feby 5 1921

20 UNDERTAKER: N E Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. PHYSICIANS should state whether the deceased may be properly classified. Exact statement of OCCUPATION should be given. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Eliz. 6. Murry

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050492 64 1050492

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Mitrage ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth B Murry

(Residence in Baltimore: No. 305 Mitrage ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 18, 1867
(Month) (Day) (Year)

7-AGE, 63 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Mfr
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), N.Y.

PARENTS.

10-NAME OF FATHER, Edw Turner

11-BIRTHPLACE OF FATHER (State or Country), Engen

12-MAIDEN NAME OF MOTHER, Ann Eales

13-BIRTHPLACE OF MOTHER (State or Country), Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Murry

(Address) 305 Mitrage

15- Filed FEB 4 - 1921 1921 ROBERT P. KRAUTH Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Feb 2 1921, that I saw h[illegible] alive on Feb 1 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma - Ovaries

(Duration) yrs. 1 mos. ds.

(Signed) A B Lemmon M. D.

2/4/21, 191... (Address) 1824 Pallen St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery DATE OF BURIAL, 2/7/1921

20-UNDERTAKER W J Pickum & Sons ADDRESS Mt & Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050493 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050493

CERTIFICATE OF DEATH. X91-090

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Caroline St ST.: B WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Rubin

(a) RESIDENCE. No. 208 S. Caroline St ST., WARD. Russia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Brana Rubin

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schecter

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unkown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1411 E Balto St

15 Filed FEB 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 3, 1921, that I last saw him alive on Feb 3, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jack Lewis, M. D.

2/3, 1921 (Address) 2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Rosedale — DATE OF BURIAL: 2/4 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Ridgely St ST.; 25 WARD)

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jackson

(a) RESIDENCE. No. 118 Ridgely St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Jackson

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. ....min.
	57	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John Jackson
(Address) 118 Ridgely St

15 Filed FEB 4 - 1921 ROBERT E. CHAUTEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Feb 2, 1921, that I last saw h.. alive on Feb 1, 1921, and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) no yrs. no mos. 6 ds.

CONTRIBUTORY (Secondary) General paralysis

(duration) no yrs. no mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? paralysis

(Signed) R. W. Adams, M. D.

Feb 3, 1921 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	2/4 19 21
20 UNDERTAKER	ADDRESS
Wm Scott Hooper	426 Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50495 HEALTH DEPARTMENT—CITY OF BALTIMORE D50495

CERTIFICATE OF DEATH.

182 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 228 Rock ST.: 18 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Williams

(Residence in Baltimore: No. 228 Rock st-

St. 1 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
29 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 10
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Ala. Alabama

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Williams

(Address) 1035 N Longston st

15- FEB4-1921 Filed ....., 191.... ROBERT J KRAUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or ~~inquiry~~) thereon and from the evidence obtained by said (Inquest, au) and that said deceased came to his death (topsy or ~~inquiry~~) on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in his right shoulder by Annie M Boyd

(Duration) yrs. a few mos. ds.

CONTRIBUTORY (Secondary) as above

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

2-3-, 1921 (Address) 117 W Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 4, 1921
20-UNDERTAKER Brown & Sheeland	ADDRESS 1140 W Lexington st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 1050496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 879 Park Ave ST. 11 WARD)

2-FULL NAME Adaline Clarke

(a) RESIDENCE. No. 1208 John ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14. 1859

7 AGE Years 61. Months 8 Days 28 | If LESS than 1 day, ...hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Maryland

PARENTS

10 NAME OF FATHER David Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pr. Georges Md

12 MAIDEN NAME OF MOTHER Pratt

13 BIRTHPLACE OF MOTHER (city or town) Marlboro (State or country) Maryland

14 Informant Rachel Clarke Mackey (Address) 879 Park Ave

15. Filed FEB 4 - 1921 ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1921, to Feb 2nd, 1921, that I last saw h E alive on Feb 2nd, 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Not Obtained

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. B. Gambrill Jr. M. D.

. 19 (Address) 26 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 2-4 1921

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard and Calhoun

CAUSE OF DEATH should be stated EXACTLY. Every item of information requested should be furnished, if obtainable by reasonable diligence. AGE should be stated in years, months, and days. PHYSICIANS should write plainly, in ink, and in terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Margaret Myles

D50497 D50497

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Margaret Myles ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo J Kaufman

(a) RESIDENCE. NO. Geo J Kaufman ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. 4 mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Wm.	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Geo Myles.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant .....
(Address) 2317 Division

15 FEB 4 - 1921 ROBERT P. BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to Feb 2, 1921, that I last saw h[illegible] alive on Feb 2, 1921, and that death occurred, on the date stated above, at 12 — m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry Engman, M. D.

, 19 (Address) 1716 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Feb 5th 1921

20 UNDERTAKER: Crefeld & Pascal — ADDRESS: 2317 Div.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050498 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050498

63-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Greenwillow ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mariam Scott

(a) RESIDENCE. No. 510 Greenwillow st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE one Years Months 4 Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER William Scott

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER nellie Bennet

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant nellie Scott (Address) 510 greenwillow st

15 Filed FEB 4 - 1921 ROBT. J. BRASTEN Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3/1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1921, to Feb. 3, 1921, that I last saw h[illegible] alive on Feb. 2nd, 1921, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Pyaemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Infantal Paralysis

(duration) about yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno A. Compton, M. D.

19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount auburn Cemetery

DATE OF BURIAL: Feb 4 1921

20 UNDERTAKER: John H. Toadvine

ADDRESS: 1420 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L050499

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050499

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 105 N Randall ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horatio Bowersox

(a) RESIDENCE. No. 105 N Randall ST., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Horatio Bowersox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louis F Bowersox (Address) 105 N Randall

15 FEB 4 - 1921 ROBERT J. KRAUTER Registrar

FEB4 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1921, to Feb 2, 1921, that I last saw him alive on Feb 2, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac dilitation.

OVER

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Bowersox, M. D.

2-3-1921 (Address) 105 N Randall

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 4 1921

20 UNDERTAKER M J & E Evans & Sons, 1428 Eutaw

ADDRESS

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. AGE should be supplied, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No valvular lesion
No hemorrhage.
Primary arteriosclerosis
no further history.

Spec.—8-24-14—M. & T.—2000 Bks.

1050500

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 W. North Ave St.: 15 WARD)

REGISTERED No. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Blake

(Residence in Baltimore: No. 1835 W. North Ave St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 14, 1853 (Month) (Day) (Year)

7-AGE, 68 yrs. 11 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Commission Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 45

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, John Lewis Blake.

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Blake

(Address) 1835 W. North Ave

15- Filed FEB 4 - 1921, 191 ROBERT E KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 2, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1921, to Feb. 2 1921, that I saw him alive on Feb. 2 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(Duration) yrs. mos. 5 ds.

(Signed) Herbert C. Blake M. D.

Feb. 2, 1921 (Address) 1014 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Feb. 5th, 1921

20-UNDERTAKER Martin Fahey & Son ADDRESS 827 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

050501 — 050501

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3112 Remington Ave ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R Stone

(Residence in Baltimore: No. 3112 Remington Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1851 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Builder
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country): Frederick Co Md.

PARENTS.

10-NAME OF FATHER: W B Stone

11-BIRTHPLACE OF FATHER (State or Country): Frederick Co Md.

12-MAIDEN NAME OF MOTHER: Susan Schaffer

13-BIRTHPLACE OF MOTHER (State or Country): Frederick Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stone

(Address) 3112 Remington Ave

15- FEB4-1921 Filed ....., 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Feb 2 1921, that I saw him alive on Feb 2 1921, and that death occurred, on the date stated above, at 7-10 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Left lower lobe)

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. C. Shelley M. D.

Feb 2, 1921. (Address) 3549 Eldondale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, Feb ....., 1921

20-UNDERTAKER M E Gossom — ADDRESS 840 W 37th St.

IMPORTANT. PHYSICIANS should write CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50502

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 St. Paul ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliana L. P. Daniels

(a) RESIDENCE No. 2018 St. Paul ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastern Shore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Paca

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Esther Nicholson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Juliana Daniels
(Address) 2018 St. Paul St

15 Filed FEB 4 1921 ROBERT A KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1920, to Dec. 23, 1920, that I last saw h[er] alive on Dec. 23, 1920, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Sudden. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senility & Bronchitis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of No.

Was there an autopsy? No.

What test confirmed diagnosis? Physical.

(Signed) Milton P. Hill M. D.

19 (Address) 109 Lis ons + Pentalon Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Feb 5th 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050503

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050503

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 E. Fort ave ST.: 24 WARD 64)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Sheckells

(a) RESIDENCE. NO. 807 E. Fort av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent R. Sheckells

6 DATE OF BIRTH (month, day, and year) Dec. 11 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	73	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Potter Rider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Vincent R. Sheckells

(Address) 724 E. Fort ave

Filed FEB 4 - 1921

ROBERT A. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1921, to Feby 3, 1921, that I last saw h[illegible] alive on Feby 3, 1921, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. P. Smith M. D.

, 19 (Address) 109 N. Eu[illegible] St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Feb. 5 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

N 50504

HEALTH DEPARTMENT—CITY OF BALTIMORE

N 50504

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Lakewood Ave. St.; 26th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm John Oliphant

(Residence in Baltimore: No. 3416 Mystic Place St.; yrs. 3 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White.	Single

6-DATE OF BIRTH, October 20, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 17 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 0-0

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, William N. Oliphant.

11-BIRTHPLACE OF FATHER (State or Country), Balto city.

12-MAIDEN NAME OF MOTHER Mary C. Fritzler

13-BIRTHPLACE OF MOTHER (State or Country), Balto city.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Fritzler Oliphant

(Address) 3416 Mystic Place.

15- FEB 4 - 1921 ROBERT J. KRAUTER

Filed ..., 191... Registrar.

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 2 1921, to Feb. 3 1921, that I saw h... alive on Feb. 2 1921, and that death occurred, on the date stated above, at 6:20 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) Geo. Heller M. D.

..., 191... (Address) 1937 Vaughan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Sacred Heart Cem.	Feb. 4, 1921
20-UNDERTAKER	**ADDRESS**
Tilly & Zirkin.	403 S. Moffet

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050505 — HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1050505

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.: W. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Miller (Mueller)

(a) RESIDENCE. NO. 3311 Hudson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 — 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Dry Docks.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. co. Md.

PARENTS

10 NAME OF FATHER Nicolas Mueller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Theresa Wolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Amelia Mueller.

(Address) 3311 Hudson St.

15 Filed FEB 4 - 1921 BOYD I. LAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from January 26 1921, to Feb 2 1921

that I last saw him alive on Feb 2 1921

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Jan 28.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. Schweinitz M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 5th 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division St. ST.: 16 WARD) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minan S. Duncan

(a) RESIDENCE. No. 1209 W. Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 26-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchandise broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Scotland~~ New York
(State or country)

PARENTS

10 NAME OF FATHER James Duncan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabella Stevenson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Geo W Little
(Address) 531 N Fremont Ave

15 FEB 4 - 1921 ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to Feb 4, 1921, that I last saw him alive on Feb 4, 1921, and that death occurred, on the date stated above, at 8 40 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical —

(Signed) Duff Kinney M. D.

Feb 4, 1921 (Address) Union Memorial Hospital. 1514 Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Western	Feb 6 1921
20 UNDERTAKER Geo W Little	ADDRESS 531 N Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050507

HEALTH DEPARTMENT—CITY OF BALTIMORE

050507

CERTIFICATE OF DEATH.

REGISTERED NO. 24120

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1119 Battery Ave ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Parker Jordan

(a) RESIDENCE. No. 1119 - Battery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced (or) ~~HUSBAND~~ of Alvena Jordan

6 DATE OF BIRTH (month, day, and year) Mar 20 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Edenton
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Ida B. Roberts
(Address) 1119 Battery Ave

15 Filed FEB 4 - 1921 19 ROBERT J. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov - 13 - 1916, to Feb 3rd 1921, that I last saw h.ive alive on Feb. 2nd 1921, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G. S. Burton, M. D.

2/3, 1921 (Address) 30 East Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK

DATE OF BURIAL FEB 5 1921

20 UNDERTAKER JOHN F. DENNY

ADDRESS 716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050508

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050508

CERTIFICATE OF DEATH.

97

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Eckhardt.

(a) RESIDENCE. No. #1607 Edmondson Ave, ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 (Single), Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sawyer (Box factory)

(b) General nature of industry, business, or establishment in which employed (or employer): Wm Duckling & Sons

(c) Name of employer: 604 Pollard St Baltimore Md

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Eckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry F. Eckhardt

(Address): 1707 Hanover St

FEB 4 - 1921

[illegible] A. LEASTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Feb 3, 1921, that I last saw him alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart. Ward

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Emphysema

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Heyd M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 5 1921
20 UNDERTAKER	ADDRESS
Geo Peter & Son	2503 Edmondson ave

CAUSE OF DEATH should be stated EXACTLY. Every item of information should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous. No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 50509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N. Ellwood Ave ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Harry Sander

(a) RESIDENCE. NO. 610 N. Ellwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Sander

6 DATE OF BIRTH (month, day, and year): July 24th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 586

(b) General nature of industry, business, or establishment in which employed (or employer): Spinning Dept

(c) Name of employer: at Goucher.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John H. Sander.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Fischhauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Katherine Sander. (Address) 610 N. Ellwood Ave.

15 Filed FEB 4 - 1921 ROBERT J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1920, to Feb 2—, 1921, that I last saw him alive on Feb 2—, 1921, and that death occurred, on the date stated above, at 12 30 Noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E Heller Henning, M. D.

2/3, 1921 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb. 7th 1921
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John H. Deufel	851 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

...—6-9-19—H. P. Co.—1000 Bks.

50510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D.50510

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1137 W. Hamburg ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline D. Dienter

(a) RESIDENCE. No. 1137 W. Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Diener

6 DATE OF BIRTH (month, day, and year) April 14. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	9	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Philip Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William H. Diener

(Address) 1137 W. Hamburg St.

15 Filed FEB 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2nd 1921

17

I HEREBY CERTIFY, That I attended deceased from Jany 29. 1921. to Feb 2nd 1921. that I last saw h[illegible] alive on Feb 2nd 1921. and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hubert D Main M. D.

. 19 (Address) 1277 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 6 1921

20 UNDERTAKER Mr. & Mrs J. W. Imfeld & Son ADDRESS 801 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50511 — 28 — D50511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St., 18 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Abron

(a) RESIDENCE. No. 810 Bolden Alley (Born) St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Abron

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M. T. H.

15 Filed FEB4-1921 ROBERT B KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Feb. 2, 1921, that I last saw him alive on Feb. 1, 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous pneumonia

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. D. Rigney, M. D.

2-2-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

FEB 1921

Commissioner Health,

Per. Wm. E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

050512 28 050512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ball

(a) RESIDENCE. No. 1421 Tenpennie Alley ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

040

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Calvin Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) J. H. H. JOHNS

15 Filed FEB4-1921 19 ROBERT J. BREUNER Registration Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1920, to Feb. 1, 1921, that I last saw him alive on Feb. 1, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. F. Rigney, M. D.

2-1-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 4 1921

20 UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50513 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50513

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2928 E. Biddle (8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Deems

(a) RESIDENCE. No. 2028 E. Biddle ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Deems

6 DATE OF BIRTH (month, day, and year): May 9 - 1855

7 AGE: Years 65 Months 8 Days 26 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Keeper 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary J. Deems

(Address) 2028 E. Biddle

15 Filed FEB 4 - 1921, 19....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to Feb 4, 1921, that I last saw him alive on Feb 4, 1921, and that death occurred, on the date stated above, at 1.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Albert L. James M. D.

Feb 4, 1921 (Address) 1301 N Bat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore.

DATE OF BURIAL: 2-7 1921

20 UNDERTAKER: Wellman Cook

ADDRESS: 502 E Mul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the state of disease may be stated EXACTLY. PHYSICIANS' ... OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50514 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 N. Lafayette St.: 16 Ward) 28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jamie A Rowlette

(a) RESIDENCE. No. 2814 N La Fayette St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Rowlette

6 DATE OF BIRTH (month, day, and year) March 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) 08

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Rowlette

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Bertha Mae Ryan 2517 N Lafayette

Filed FEB 4 1921, 19 Robert P. Harrison, Registrar

3050 N. Howard Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25" 1921, to Feb 3" 1921, that I last saw him alive on Feb 3 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Exam. H. D.

(Signed) Herbert L. Sapp, M. D.

Feb 4 1921 (Address) 3050 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington - Delaware	Feb 6 - 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North ave

CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. PHYSICIANS should state ay be properly classified. Exact statement of OCCUPA- ack of certificates.

Spec.—6-9-19—H. P. Co.—1000 Pks.

D. 50515 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50515

CERTIFICATE OF DEATH. 134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1839 Rutland Ave (ST.) 8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanna F Evans

(a) RESIDENCE. No. 1839 Rutland Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E Evans

6 DATE OF BIRTH (month, day, and year): Dec 30 1898

7 AGE — Years: 22 — Months: 1 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Va

PARENTS

10 NAME OF FATHER: James W Fahrnstock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pittsburg Pa

12 MAIDEN NAME OF MOTHER: Emily B Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg Pa

14 Informant: Charles E Evans
(Address) 1520 N Royal Ave

15 Filed FEB 4 - 1921 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1920, to Feb 3, 1921, that I last saw h.. alive on Feb 3, 1921, and that death occurred, on the date stated above, at 11 10 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis Pericarditis

(duration) yrs. 3 mos. 4 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1520 N Royal Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

2-3, 1921 (Address) 2042 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisburg Pa — DATE OF BURIAL: Feb 5 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 528 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

050516

HEALTH DEPARTMENT—CITY OF BALTIMORE

050516

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Barnes St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet L. Jones

(Residence in Baltimore: No. 2625 Hoope St St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 18th, 1899 (Month) (Day) (Year)

7-AGE, 21 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Harriet Cornish

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Harriet Jones

(Address)..... 2625 Barnes St

15-

Filed ....., 191.... Robert P. Harrison

Registrar.

FEB 4 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 3rd, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7th 1920, to Dec 7th 1920, that I saw her alive on Dec 31st 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration)..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Feb 3 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL, Eastern Cem Md — DATE OF BURIAL, Feb 5, 1921

20-UNDERTAKER ..... ADDRESS .....

JAMES F. DENNIS
1303 PRESTMAN ST

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50517 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50517

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Park ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine Tazewell Watkins

(a) RESIDENCE. No. 1516 Park ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	X	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Town Chester Virginia

PARENTS

10 NAME OF FATHER M Carol Watkins

11 BIRTHPLACE OF FATHER (city or town) Winchester (State or country) Virginia

12 MAIDEN NAME OF MOTHER Hortense R. Tatum

13 BIRTHPLACE OF MOTHER (city or town) St Augustine (State or country) Florida

14 Informant Hamilton L. Watkins (Address) 1516 Park ave

15 Filed Robert P. Harrison, Registrar

B4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1919, to Feb. 3rd, 1921, that I last saw her alive on Feb 3rd, 1921, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

OVER

Hemiplegia -

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Watson, M. D.

, 19 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feby 5 1921
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Carolina Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... should be stated EXACTLY. PHYSICIANS ... should state ... of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50518 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50518

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Mens Home ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Snooks

(a) RESIDENCE. No. 1400 W Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): ? 1848

7 AGE: Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Phil. Snook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Eliza M. Hammett

13 BIRTHPLACE OF MOTHER (City or town) (State or country): St. Mary's Co Md

14 Informant (Address): H.W. Gillman Matron

15 Filed FEB 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug, 1920, to Feb. 4, 1921, that I last saw h..... alive on Feb 4, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia over

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Norwood M. D.

Feb 4, 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb 7 1921

20 UNDERTAKER: Geo J Smith

ADDRESS 1000 W. Fayette St

FEB 4 1921

Be stated EXACTLY. PHYSICIAN should be state
y be properly classified. Exact statement of OCCUPA-
k of certificates.
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not apoplectic

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 50519 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50519

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Binney ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Baust.

(a) RESIDENCE. NO. 1111 Binney ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Baust.

6 DATE OF BIRTH (month, day, and year) Feb. 2nd 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Finnerty.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Cooney

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country)

14 Informant Margaret Finnerty (Mother)

(Address) 1109 Binney St.

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from October —, 1920, to Feb 2, 1921, that I last saw h[illegible] alive on Feb 1, 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia & exhaustion

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) yrs. 5 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. V. Wright, M. D.

2/3. 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Feb. 5th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	405 S. Wolfe

WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Any information should be carefully supplied. AGE should be carefully supplied. EACH CAUSE OF DEATH in plain words—so that it may be understood. Any abbreviations so that it may be understood. Any abbreviations on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50520 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50520

CERTIFICATE OF DEATH. 9-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1920 E. Fayett ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary L. Tate

(a) RESIDENCE. No. 1930 E. Fayett ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) Nov. 4- 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: George L. Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louise Shay.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: George L. Tate (Address) 1920 E. Fayette St.

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to Feb 4, 1921, that I last saw h[illegible] alive on 2-4, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Toxemia from Diphtheria

Ascending Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2-4 1921 (Address) 3323 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 5th 1921
20 UNDERTAKER: Lilly & Zeiler	ADDRESS: 403 S. Wolfe St

N. B.—WRITE PLAINLY. All information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50521

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 747 W. North ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa R. Muth

(a) RESIDENCE. NO. 747 W. North ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Louis F Muth

6 DATE OF BIRTH (month, day, and year) August 30th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Friederick Feigl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Louis F Muth 747 W North ave

15 Filed FEB 5 1921 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1921, to Feb 4th, 1921, that I last saw her alive on Feb 3d, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feby 7th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Mount

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

no other Cause

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50522 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50522

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 E. North ave St. 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd E. Mitchell

(a) RESIDENCE. No. 1125 E North ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mary L Mitchell

6 DATE OF BIRTH (month, day, and year) April 13th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Frances A R Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary L Mitchell

(Address) 1126 E North

15 Filed FEB 5 - 1921, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from January 31st, 1921, to Oct 3rd, 1921, that I last saw him alive on Oct 3rd, 1921, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage Left side

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Davis, M. D.

, 19 (Address) 2432 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Baltimore Cemetery	Feby 7th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

F. B.—WRITE PLAINLY. WITH ... mation should be carefully supplied. Age, ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50523 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50523

CERTIFICATE OF DEATH.

REGISTERED No. C 4157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Prentiss ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Phelan

(Residence in Baltimore: No. 312 Prentiss St.; — yrs., — mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, Jan. (Month) 28 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
— yrs. — mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto. City Md.

PARENTS.

10-NAME OF FATHER, Wm. L. Phelan

11-BIRTHPLACE OF FATHER (State or Country), Eastern Pa.

12-MAIDEN NAME OF MOTHER Mary Brennan

13-BIRTHPLACE OF MOTHER (State or Country), Eastern Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Phelan

(Address) 312 Prentiss St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Cl...

FEB 5 1921

N.B.—Every item of information must be given, so that it may be known that no CAUSE OF DEATH in plain terms, as that is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 28 1921, to Feb. 3- 1921, that I saw h[illegible] alive on Feb 3- 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Entogrowth development

Weight only 4½ lbs.

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Mrs. Wm. Phelan M. D.

Feb 4, 1921. (Address) 906 N Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Feb. 5, 1921

20-UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D.50524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50524

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S. Washington ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Stone Sr.

(a) RESIDENCE. No. 211 S. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel V. Stone

6 DATE OF BIRTH (month, day, and year) Oct. 28 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Joseph Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Wightson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rachel V. Stone

(Address) 211 S. Washington St.

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17

I HEREBY CERTIFY, That I attended deceased from 1911, 19..., to Feb 2, 19 21.

that I last saw h... alive on Feb 2, 19 21.

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Leo Keller, M. D.

2/4/21, 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb. 5 1921
20 UNDERTAKER	**ADDRESS**
Wm. E. Black	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50525 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50525

CERTIFICATE OF DEATH.

40

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Pennsylvania ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Startt

(Residence in Baltimore: No. 1903 Pennsylvania ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1848 (Year)

7-AGE, 72 yrs. 3 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Christn Md

PARENTS.

10-NAME OF FATHER, David Gardner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Goodman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene Gris

(Address) 1929 Pennsylvania ave

15- FEB 5 - 1921, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 4 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920, to Feb. 3d 1921, that I saw h[illegible] alive on Feb. 3d 1921, and that death occurred, on the date stated above, at 1 20 p.m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Incontinence of food.

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Benj. Haden M. D.

Feb. 4, 1921. (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Christn Md

DATE OF BURIAL, Feb. 15, 191.1.

20-UNDERTAKER Geo A. Gerbig.

ADDRESS 2001 W. Balto St.

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50526 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50526

CERTIFICATE OF DEATH.

502

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1115 Ridgely ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Miller

(a) RESIDENCE. No. 1115 Ridgely ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? 63 yrs. 4 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Miller

6 DATE OF BIRTH (month, day, and year) Sept. 29-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Makes

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fredrick Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sophia Haag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Miller (Address) 1115 Ridgely

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1921, to Feb. 3, 1921, that I last saw h was alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Pleurisy Empy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pleurisy Influenza

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Eccles Brack, M. D.

2/4 1921 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	2/7 1921
20 UNDERTAKER	ADDRESS
I. Fow McCully	130 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case where any information can be obtained, and if not over one year, the age should be stated in hours or days. If deceased was married, widowed or divorced, the name of husband or wife should be given in full. CAUSE OF DEATH should be carefully supplied. Exact and definite statement of the disease or injury should be made, and if it may be properly classified. Exact and definite statement of the disease or injury should be made, and if it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact and definite statement of the disease or injury should be made, and if it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.50527 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Asylum WARD) 104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvadore Dantoni

(a) RESIDENCE. NO. St Vincent Asylum WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rev Matthew (Address) St Vincent Asylum

15 Filed FEB 5 - 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Feb 2, 1921, that I last saw h... alive on July 1, 1921, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Dermatitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas P Clemens M. D.

Feb 3 1921 (Address) 1504 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Feb 5 1921

20 UNDERTAKER John A Mitchell ADDRESS 1201 W Fayette

MARGIN (...) CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50528 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50528

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 N. Stricker St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn C. Nickole

(a) RESIDENCE. No. 834 N. Stricker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 5 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk dcg

(b) General nature of industry, business, or establishment in which employed (or employer) Building Contractors

(c) Name of employer Singer, Penty & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John E. Nickole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Maryland

12 MAIDEN NAME OF MOTHER Lillie A. Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Monroe North Carolina

14 Informant John R. Nickols
(Address) 834 N. Stricker St

15 Filed FEB 5 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17 1921, to Feb 3 1921, that I last saw h[illegible] alive on Feb 2nd 1921, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

about (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) Do not know yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? T.B. Bacilli in Sputum

(Signed) Edward C. Smith M. D.

2/3, 1921 (Address) 237 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine cemetery	19
20 UNDERTAKER Leo G. Cook	ADDRESS 1900 Harford Ave

...mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be ...TION is very important. See instructions on back of ...

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50529 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50529

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. NO. 130 Winter ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Brooks

(a) RESIDENCE. NO. 130 Winter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Shoeman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Bessie Hunt

(Address) 134 W West St.

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/22/21, 19..., to 2/3/21, 19 21, that I last saw h... alive on 2/4/21, 19 21, and that death occurred, on the date stated above, at 11.07 p.m.

The CAUSE OF DEATH* was as follows: Dr

Uremia

CONTRIBUTORY (Secondary) (duration) 3 mos. ds. (Cres) Sub-acute nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Burley, M. D.

2/5/21 19 (Address) 908 D Shore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL Feb 6 1921

H.H. Clubman & Co

20 UNDERTAKER Samuel A Hawley ADDRESS 978 Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact information should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied, so that it may be properly classified. AGE in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

D.50530 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1621 Walker St, 7 WARD) REGISTERED No. C 91

2-FULL NAME Mary E. Mitchell

(Residence in Baltimore: No. 1621 Walker St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, Col'd | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 20, 1850
(Month) (Day) (Year)

7-AGE, 70 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Jacob Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Viola Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Mitchell

(Address) 1621 Walker St

15-

FEB 5 - 1921 Robert P. Harrison, 191.....
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb. 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Disease

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

2422 Eutaw Place (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL, Feb. 7, 1921

20-UNDERTAKER Samuel Hendley ADDRESS W. Balto

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Cause important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50531

CERTIFICATE OF DEATH.

X 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 705 S. 4th ST.: 56 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Higgs

(a) RESIDENCE. NO. 705 S. 4th ST., WARD. Solomons Isl. Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Higgs

6 DATE OF BIRTH (month, day, and year) Sept 9-53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Co, Md

PARENTS

10 NAME OF FATHER John Mattingly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John H. Higgs St Mary Co. Md

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1921, to Feb 4 1921,

that I last saw h alive on 19

and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Dec 5 Dry.
Exhaustion
Uraemia Coma
(duration) x yrs. x mos. x ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (duration) x yrs. 4 mos. x ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Jas E. Fraas, M. D.

2/6/4 1921 (Address) 248 So 22d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solomons Island

DATE OF BURIAL Feb 5 1921

ADDRESS 2016 Orleans

20 UNDERTAKER Philip Herwig

N. B.—WRITE PLAINLY. Every question should be carefully answered. Information should be carefully supplied, so that it may be of value. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50532

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50532

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Ursulmond Ave. WARD) 15

2-FULL NAME Raymond Stanley Price

(a) RESIDENCE. NO. 2914 Ursulmond Ave. WARD. Balto

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1920

7 AGE — Years: — Months: 7 Days: 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dept. Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Dept. Grocer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Raymond Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Bessie Gumdel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Raymond Price 2914 Ursulmond Ave

Filed 1921 Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/31 1921, to 2/4 1921, that I last saw h— alive on 2/4 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchites

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lumbar Eczema (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. J. Stanley Gosnell M.D.

2/4 1921 (Address) 2900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Feb. 7 1921

20 UNDERTAKER: Wm Cook

ADDRESS: [illegible] E. Mt. Ver.

WRITE PLAINLY. Age should be properly classified. Age should be carefully supplied, so that it may be properly classified. See instructions on back of certificates. mation should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

E85

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50533 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50533

D.50533

CERTIFICATE OF DEATH. -20

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3413 Pourtalow Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Williams

(a) RESIDENCE. NO. 3413 Pourtalow ST. WARD. 4

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Chew Williams

6 DATE OF BIRTH (month, day, and year) Sept 5 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Tobacco Md.

PARENTS

10 NAME OF FATHER John Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Catherine Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Chew Williams

(Address) 3413 Pourtalow St.

15 Filed ..... 192 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1920, to Feb 3rd, 1921, that I last saw h[er] alive on Feb 2nd, 1921, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene induced by ingrown nail of Rt Great toe

(duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Cystitis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 8 1921

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Chas. B. Fegan, M. D.

(Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 5 192[1]

20 UNDERTAKER Wm Cook

ADDRESS N. Y.

N. B.—WRITE PLAINLY, WITH CARE. AGE should be properly classified. AGE should be carefully supplied. All information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

FEB 8 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50534 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50534

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1309 N North Ave St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Gill

(a) RESIDENCE. No. 1309 N North Ave Ward. M.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes M Gill

6 DATE OF BIRTH (month, day, and year): Nov 7 1842

7 AGE: Years 79 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 031

(b) General nature of industry, business, or establishment in which employed (or employer): Machinist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Thomas Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Agnes M Gill (Address) 1309 N Ave

15 Filed Feb 5, 1921 Robert P. Harrison, Registrar

FEB5-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 26, 1920, to July 3, 1921, that I last saw h... alive on July 3, 1921, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Eyelid

(duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lester McGuire, M. D.

, 19 21 (Address) 1306 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 7 1921

20 UNDERTAKER: W. Lee Cook — ADDRESS: 532 E Baltimore

N. B.—WRITE PLAINLY. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

20.5053 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50535

CERTIFICATE OF DEATH.

167

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1926 Wilhelm St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. O'Loughlin

(Residence in Baltimore: No. 1926 Wilhelm St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, March (Month) 2 (Day), 1919 (Year)

7-AGE, 1 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establisbment in wbich employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Edward J. Loughlin

11-BIRTHPLACE OF FATHER (State or Country), Balto city

12-MAIDEN NAME OF MOTHER Viola M. Lehnert

13-BIRTHPLACE OF MOTHER (State or Country), Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola O'Loughlin

(Address) 1926 Wilhelm St

15- Robert P. Harrison,

Filed FEB 5 1921, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ? death on the day stated above.

The CAUSE OF DEATH* was as follows:
3a Burns over abdomen & thighs 1 hr by pulling cup hot
Chopee on Gas accident
(Duration) yrs. mos. 1 ds.

CONTRIBUTORY.....
(Secondary)
(Duration) yrs. mos. ds.

(Signed) James M. Burton M. D.
(Coroner.)
Feb 6, 1921. (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deatbs from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whetber ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Feb 5, 1921

20-UNDERTAKER John J. Cowan Son — ADDRESS 901 Hollins St

N.B.—Every item of information should be carefully supplied. Each CAUSE OF DEATH in plain terms, so that it may be properly classified. Dates important. See instructions on back of certificate.

D.50536 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50536

CERTIFICATE OF DEATH.

X 186

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Emory Currens

(Residence in Baltimore: No. Franklin Square Hospital St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..July.. (Month) ..19.. (Day), 1879 (Year)

7-AGE, ..41.. yrs. ..6.. mos. ..16.. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laboring Work.

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER. Robert Currens.

11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER Ella Shue.

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella Currens (wife)

(Address) LongGreen, Balto. Co., Md.

15- Robert F. Harrison,

Filed FEB 5 - 1921, 191.. Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..Feb.. (Month) ..4.., (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..his.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull, Caused by Cyclone by wooden fence falling on him, while going to work. Accident

(Duration) ..yrs. ..mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..yrs. ..mos. ..ds.

(Signed) James H. Preston M. D. (Coroner.)

Feb. 5, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State -- - 3 ..15.. yrs. ..?.. mos. ..?.. ds.

Where was disease contracted, if not at place of death? .....

LongGreen, Balto. Co., Md.

Former or usual residence LongGreen, Md.

19-PLACE OF BURIAL OR REMOVAL, LongGreen, Balto. Co., Md.

DATE OF BURIAL, Feb-5-/21, 19..

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50537 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50537

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 W. Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Godwin

(a) RESIDENCE. NO. 1502 W. Lanvale ST., WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. 1 mos. 14 ds. How long in U. S., If of foreign birth? 91 yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George D. Godwin

6 DATE OF BIRTH (month, day, and year) Dec-30-1829

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER J. Hugh Brown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Farmer

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) England

14 Informant Mr. Thos. Edw. Godwin (Son)

(Address) 1502 W. Lanvale St

Filed FEB 5 1921, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 29, 1921, to Feby 3, 1921, that I last saw h~~e~~r alive on Feby 3, 1921, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Indefinite

~~Not known~~ (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Indefinite.

Did an operation precede death? No Date of —

Was there an autopsy? No. Chemical & microscopic.

What test confirmed diagnosis?

(Signed) J. H. Arthur, M. D.

, 19 (Address) 1426 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feby 19-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AV

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

20,50538 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,50538

CERTIFICATE OF DEATH.

REGISTERED No. C 9 17+

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: WARD)
2-FULL NAME "Denis" J. Laraner
(Residence in Baltimore: No. 1304 Hillman St.; 50 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married
6-DATE OF BIRTH, November (Month), (Day), 1857 (Year)
7-AGE, 63 yrs. 2 mos. ds.
If LESS than 1 day, ...hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer) Shipyard
9-BIRTHPLACE, (State or Country), Ireland
PARENTS.
10-NAME OF FATHER, John Laraner
11-BIRTHPLACE OF FATHER (State or Country), Ireland
12-MAIDEN NAME OF MOTHER Ellen Glenn
13-BIRTHPLACE OF MOTHER (State or Country), Ireland
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Laraner
(Address) 1304 Hillman St.
15- Filed FEB 5 1921, 191 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month), 2 (Day), 1921 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Ruptured liver
5 hrs.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Accident Shipyard Balto. Dry Docks
(Duration) yrs. mos. ds.
(Signed) J. J. Hennessy M. D.
(Coroner.)
Feb. 4, 1921 (Address) 2802 E. Fountain

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death? Balto. Dry Docks
Former or usual residence 1304 Hillman St.

19-PLACE OF BURIAL OR REMOVAL, Cathedral
DATE OF BURIAL, Feb. 7, 1921
20-UNDERTAKER H. C. Wiedefeld
ADDRESS 914 Greenmount

Burial Permit Clerk.

N. B.—Every item of information should be entered, so that it may be property CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50539 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50539

CERTIFICATE OF DEATH.

82

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 3213 E. Baltimore ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Frampton

(a) RESIDENCE. No. 3213 E. Baltimore ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte J. Frampton

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner 086

(b) General nature of industry, business, or establishment in which employed (or employer) Captain of Ferry steamer

(c) Name of employer City Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Howard Frampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliz. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charlotte J. Frampton
(Address) 3213 E. Baltimore St.

15 Filed FEB 5 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE plainly and fill all blanks. Information should be carefully supplied, so that it may be permanently recorded. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2d, 1921, to Feb 3, 1921, that I last saw him alive on Feb 3d, 1921, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolus.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical exam.

(Signed) Benj. Kader, M. D.

2-5, 1921 (Address) 252 N. Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Feb 6 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1100 Reed

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50540 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50540

CERTIFICATE OF DEATH. 18-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 26 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Brown

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Laura Langley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Records, New City Hospital.

Filed FEB 5 1921, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

N. B.—[illegible] mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be understood on back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2, 1921

17

I HEREBY CERTIFY, That I attended deceased from January 22, 1921 to February 2, 1921, that I last saw him alive on February 2, 1921, and that death occurred, on the date stated above, at 12:40 P.m.

The CAUSE OF DEATH* was as follows:

Erysipelas.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test.

(Signed) V. A. Herman, M. D.

2/3/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	FEB 5 1921
20 UNDERTAKER Commissioner Health.	ADDRESS
Wm. F. WOODALL	

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50541

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50541

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 2 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McDowell

(a) RESIDENCE. No. New City Hospital ST. WARD.

(Usual place of abode) Thomas Mills Mission, Tells Pt. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O.H.C.

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) New berg N.Y.

PARENTS

10 NAME OF FATHER Wm. Mc Dowell

11 BIRTHPLACE OF FATHER (city or town) New Berg (State or country) N.Y.

12 MAIDEN NAME OF MOTHER ——

13 BIRTHPLACE OF MOTHER (city or town) New Berg (State or country) N.Y.

14 Informant New City Hosp Records (Address)

15 Filed ....., 19.. Robert P. Harrison Registrar

FEB 5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1921, to 2-2, 1921, that I last saw h.. im alive on 2-1, 1921, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Abscess of right thigh (Diabetic).

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? yes Date of 1-31-21

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. G. Holden, M. D.

2-2 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	FEB 5 1921
20 UNDERTAKER	ADDRESS
Commissioner Health,	

For Wm. F. WOODALL

mation should be given in answering these questions. CAUSE OF DEATH in plain terms, so that it may be readily understood. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50542 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50542

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Robinson

(a) RESIDENCE. No. 1929 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie F Robinson

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Moses Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nellie F Robinson (Address) 1929 McCulloh

15 Filed FEB 5 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1921

17 I HEREBY CERTIFY, That I attended deceased from December 4, 1920, to February 2, 1921, that I last saw him alive on February 2, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H S McCard M. D.

2/4, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 5 1921
20 UNDERTAKER	ADDRESS
George H. Holland	163 Knight Ave

N. B.—WHITE PAPER should be carefully supplied, so that information should be carefully supplied, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

EB5 - 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50543 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50543

CERTIFICATE OF DEATH.

145 54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Johnson

(a) RESIDENCE. No. 1917 Division St ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Sarah Johnson

6 DATE OF BIRTH (month, day, and year) May 14 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher 18

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Indies
(State or country)

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) West Indies
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bailey

13 BIRTHPLACE OF MOTHER (city or town) West Indies
(State or country)

14 Informant Hospital Record
(Address)

15 Filed Feb 5 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to February 2, 1921, that I last saw h... alive on February 2, 1921, and that death occurred, on the date stated above, at 145 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) ... yrs. 11 mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... moe. ... ds.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Examination

(Signed) U. K. Mason, M. D.

Feb 3 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem.	Feb 6 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

mation should be entered in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

FEB 5 1921

D50544 HEALTH DEPARTMENT—CITY OF BALTIMORE D50544

CERTIFICATE OF DEATH.

156

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1508 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie E. Jones

(Residence in Baltimore: No. 1508 N. Caroline St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Jan., 11th., 1863.
(Month) (Day) (Year)

7-AGE, 58 yrs. 0 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Porter

11-BIRTHPLACE OF FATHER (State or Country). Scotland

12-MAIDEN NAME OF MOTHER Elizabeth McKee

13-BIRTHPLACE OF MOTHER (State or Country) Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Robert Jones

(Address) 1508 N. Caroline St.

15-

Filed..... 191 Robert P. Harrison, Registrar.

FEB 5 1921

Burial Permit Clerk.

N.B.—Every item of information should be carefully considered, and CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 3rd. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by Pneumonia

Yes! (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) H. Ford Thelen M. D.
(Coroner)

2-5-, 191, (Address) 14 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery, DATE OF BURIAL, 2/5/21., 19....

20-UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt. Royal Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50545 ✓ D.50545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Alice Thomas

(a) RESIDENCE. NO. 2629 E. Fayette ST., Hillsdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Fletcher Thomas

6 DATE OF BIRTH (month, day, and year) Feb 24 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S

12 MAIDEN NAME OF MOTHER Mary Holton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant Mrs. C. Fletcher Thomas
(Address) 2629 Hillsdale Ave

15 Filed FEB 5 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 4, 1921, that I last saw h[illegible] alive on Feb 4, 1921, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb 4, 1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. C. Marino, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feby 7 1921

20 UNDERTAKER: Henry Hoerth Son — ADDRESS: 1301 E Eager

mation should be ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50546 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50546

CERTIFICATE OF DEATH.

REGISTERED NO. 1464

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1528 McCulloh ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Byrne

(a) RESIDENCE. NO. 1528 McCulloh ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bedford Co., Pennsylvania

PARENTS

10 NAME OF FATHER Edward Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Bessie Byrne
(Address) 1528 McCulloh Street

15 Filed ..... Robert P. Harrison, Registrar

FEB5 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1921, to Feb. 3, 1921, that I last saw h.. alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1528 Linn

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardio-renal type

(Signed) Chas. O'Donnell, M. D.

Feb 5, 1921 (Address) 1528 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/7, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—Write plainly. Information should be carefully given, in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D.50547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50547

CERTIFICATE OF DEATH. REGISTERED NO. 92

1-PLACE OF DEATH St Agnes Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. 25 ST.: WARD)

2-FULL NAME Mother Anthony / Francis De Hieds / St Marys

(a) RESIDENCE. NO. St. Mary's Industrial ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1858

7 AGE: Years 62 Months 2 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) St. Mary's Industrial School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belgium

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Brother Paul

(Address) St Mary's Industrial School

15 Filed FEB 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3rd, 1921, to Feb 5th, 1921, that I last saw h[illegible] alive on Feb. 5th, 1921, and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 2/7 1921

20 UNDERTAKER Chas. D. Evans & Son

ADDRESS 1710 Druid Hill Ave

Information should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50548

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1150 Carroll Av ST.) 21 WARD)

2-FULL NAME Barbara Waldhauer

(a) RESIDENCE. NO. 1150 Carroll Av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 7th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leonard Zang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frauce Dick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs A. Schmitt

(Address) 3119 Stafford Ave.

15 [illegible] 19

Robert F. Harrison Registrar

Burial Permit Clerk

FEB5 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1 1921, to Feb 4 1921, that I last saw her alive on Feb 4 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Bile duct

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 6 1919

Was there an autopsy? no

What test confirmed diagnosis? Specimen (path)

(Signed) Reginald Fraim, M. D.

, 19 (Address) 1427 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb. 7, 1921
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Fredk Ave.

information should be given in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50549 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Raborn ST.; 4 WARD)

REGISTERED No. C 47

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Thomas White

(Residence in Baltimore: No. 706 Raborn Street St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown, ..., ... (Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Pat Clarke

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Thomas

(Address) 717 Redwood St.

15- Robert P. Harrison,

FEB 5 1921 191 Burial Permit Clerk. Registrar.

N.B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 4, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1921, to Feb 4 1921, that I saw h[illegible] alive on Feb 2 1921, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 14 ds.

(Signed) C. F. Thomas M. D.

Feb, 1921 (Address) 712 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, 2 6, 1921

20-UNDERTAKER [illegible] Fuhrhoper — ADDRESS 706 Raborn St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Caff. W 50550

No. 50550 HEALTH DEPARTMENT—CITY OF BALTIMORE X132

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. May Caff

(a) RESIDENCE. NO. Stalthorpe Md ST., WARD. Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Saw. W. Selvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Nitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Mrs. A. A Garthe Stalthorpe Md

15 Filed FEB 6 1921 ROBERT J. FRIEDEL Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-1921

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 1921, to 2-5-, 1921, that I last saw h.. alive on 2-5-, 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows: Chronic Salpingitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-4-21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy (bacteriological)

(Signed) W. H. Grading, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklin Pa. DATE OF BURIAL Feb 6 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

(Sec. back of certificate.) mation above in plain terms, so that CAUSE OF DEATH may be correctly entered. See instructions on back of CERTIFICATE. TION is very important.

[illegible] UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could give no cause for the Salpingitis

Spec.—8-24-14—M. & T.—2000 Bks.

D 50551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50551

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 S. Fourth ST.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Graham

(Residence in Baltimore: No. 922 S. Fourth St.; yrs. 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, February 9, 1920 (Month) (Day) (Year)

7-AGE, yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Richard Graham

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Rosa Webster

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Graham

(Address) 922 S. Fourth St.

15- [redacted]

Filed FEB 6 - 1921 191... Burial Permit Clerk.

Registrar.

N.B.—Every [illegible] CAUSE OF DEATH in plain [illegible] important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 4, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 4 1921, to February 4 1921, that I saw her alive on February 4 1921, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)...yrs...mos. 7 ds.

CONTRIBUTORY (Secondary) None

(Duration)...yrs...mos...ds.

(Signed) Geo. J. Lockwood M. D.

February 5 1921. (Address) 846 S. 3rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Feb 6, 1921.

20-UNDERTAKER Mary A. Vodery

ADDRESS 1126 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050552 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050552

CERTIFICATE OF DEATH. 47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S Bethel ST.; 2 WARD)

2-FULL NAME Catherine wilson

(a) RESIDENCE. No. 506 S Bethel ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ewa Delinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Catherine Delinski

(Address) 506 S Bethel

15 Filed FEB 6 — 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to Feb. 4th, 1921, that I last saw h or alive on Feb. 4th, 1921, and that death occurred, on the date stated above, at 12.45 A.m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis

(duration) abt 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (following Acute Rheumatism)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical only.

(Signed) Wm F. Lockwood M. D.

, 19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 7 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

mation should be given in plain terms, so that it may be understood by the general public. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0505 53 HEALTH DEPARTMENT—CITY OF BALTIMORE 0505 53

CERTIFICATE OF DEATH.

REGISTERED NO. C 71

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 S Chapel ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Withowski Jr

(Residence in Baltimore: No. 608 S Chapel St.; 1 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 7 (Day) 1920 (Year)

7-AGE, 1 yrs. — mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Stanislaus withowski

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Sedlak

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaus withowski

(Address) 608 S Chapel

Filed FEB 6 - 1921, 191.... ROBERT J KRAUTER Clerk

Burial Permit Registrar.

N.B.—Every answer must be written in ink. Do not use abbreviations. Write out the CAUSE OF DEATH in plain terms, so that it can be understood. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Feb 4th 1921, that I saw him alive on Feb 3 1921, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows: (Over.)

Convulsions

(Duration).....yrs.....mos...1....ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

(Duration).....yrs.....mos...1....ds.

(Signed) J. W. Dale M. D.

Feb 4, 1921 (Address) 115 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Feb 7, 1921

20-UNDERTAKER John A. Weber ADDRESS 1803 Bank St

Spec.—8-24-14—M. & T.—2000 Blks.

050554 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 050554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 28 S. Washington ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Sauer

(Residence in Baltimore: No. 28 S. Washington St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 1, (Month) (Day) 1908 (Year)

7-AGE,	If LESS than 1 day,
12 yrs. 4 mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis N. Sauer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Goetz

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Sauer

(Address) 28 S. Washington St

15- FEB 6 - 1921 Filed..... 191.... ROBERT B. ARMSTRONG Registrar

N. B. CAUSE OF DEATH must be plainly written. All questions must be answered, if possible, as the omission of any item may cause delay. Ditto marks are not permissible. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 3, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1921, to Feby 3 1921, that I saw h[illegible] alive on Feby 3 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Adolph L. Himmelheber M. D.

Feby 7, 1921 (Address) 2202 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Most Holy Redeemer	Feb 7, 1921
20-UNDERTAKER	ADDRESS
Wendell Heppel & Son	37 N. Amity

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50555 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50555

CERTIFICATE OF DEATH. 43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 S Bethel St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Johnson

(a) RESIDENCE. NO. 20 S Bethel St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) January 1879

7 AGE 41. Years — Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) born in Ind live in Ind life time

PARENTS

10 NAME OF FATHER Alfred B Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Mary Gaeang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Alice Freeman

(Address) 16 S Bethel St

15 Filed FEB 6 - 1921 ROBERT J REUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1919, to Feb 5th, 1921, that I last saw her alive on ....., 1921, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Mammary Carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Winner, M. D.

2-5, 1921 (Address) 30 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 6 1921
20 UNDERTAKER Mrs B A Elliott	ADDRESS 1725 Ashland Ave

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

050556

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

050556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 McDonough ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Jackson

(Residence in Baltimore: No. 804 McDonough St., 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1851 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Live in Baltimore 20 years Alexander, Va

PARENTS.

10-NAME OF FATHER, Moses Moxley

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary J. Tieres

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael J. Walkins

(Address) 804 McDonough St

15-

Filed FEB 6 1921, 191.....

ROBERT J. ARMOLD
Burial Permit Clerk

N.B.—Every item in CAUSE OF DEATH in plain terms, as this is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/1/1921, to 1/31/1921, that I saw her alive on 4/4/1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Failure of vital Organs

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Oldmyfield Boyle M. D.

2/7/, 1921 (Address) 42 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Feb 8, 1921.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1729 Ashland Ave

D50557 HEALTH DEPARTMENT—CITY OF BALTIMORE D50557

CERTIFICATE OF DEATH.

120

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 503 ~~N~~ Caroline ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Isaac Johnson

(Residence in Baltimore: No. 503 N Caroline St.; (yrs. 35) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, ~~Unknown~~ ....., 1867
(Month) (Day) (Year)

7-AGE, 53 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 046
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

9-BIRTHPLACE, (State or Country), lis in Baltimore 35 years Va

PARENTS.

10-NAME OF FATHER, William Johnson

11-BIRTHPLACE OF FATHER (State or Country). born in Va

12-MAIDEN NAME OF MOTHER Sarah Bailey

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 575 N Caroline St

15- FEB 6 - 1921 ROBERT P KRAUTER
Filed ..... 191... Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

2-3-, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Feb 6, 19.21.

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Ashland Av

N. B.—Every item of information above to be supplied so that it may be properly examined. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50558 — 78 — D50558

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Clifton ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Everett Auld

(a) RESIDENCE. NO. 1805 Clifton ST., ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Rosa Virginia Auld

6 DATE OF BIRTH (month, day, and year) Aug 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
40		5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Business

(c) Name of employer Atlas Chemical Lab Baltimore Md.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John E. Auld Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Auld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio Pa

14 Informant John E. Auld Jr.
(Address) 1502 N. Broadway

15 Filed FEB 6 - 1921 19... Burial Permit Issued ROBERT A. BRASHEAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1920, to Feb 4 1921, that I last saw him alive on Feb 4 1921, and that death occurred, on the date stated above, at 9 30A m.

The CAUSE OF DEATH* was as follows:

Endocarditis Septic
(Streptococcus Viridans)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs Pleurisy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Blood Culture

(Signed) Joseph Eyerdam, M. D.

(Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Feb 7 1921

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1412 Light St.

N. B.—Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

L50559 HEALTH DEPARTMENT—CITY OF BALTIMORE L050559

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathias Lieb

(a) RESIDENCE. No. 1362 Cendre Ave. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? Not Known mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lieb.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55 Years	abt			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Not Known
(State or country) Hungary

PARENTS

10 NAME OF FATHER Nicholas Lieb

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Hungary

12 MAIDEN NAME OF MOTHER Josefine Remer

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country) Hungary

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Balto md

15 FEB 6 - 1921 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1921, to Feb 4th, 1921, that I last saw h(e) alive on Feb 3rd, 1921, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis - Complicated by Nephritis -
abt
(duration) yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Mania -
abt
(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Feb 4th, 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Allen	Feb 7, 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1427 Light St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Each item may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050560 HEALTH DEPARTMENT—CITY OF BALTIMORE 050560

CERTIFICATE OF DEATH

1-PLACE OF DEATH South Baltimore Gen'l Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Cash

(a) RESIDENCE. No. 408 Grindale St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If ~~married, widowed~~ or divorced
HUSBAND of
(or) WIFE of: Mr. Joseph Cash

6 DATE OF BIRTH (month, day, and year): Jan. 23, 1875

7 AGE — Years: 46 — Months: — — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): X
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Thomas Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Gillaran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary E. Cash
(Address): Her Residence

15 Filed FEB 6 1921 Registered Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-3 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-31, 1921, to 2-3, 1921, that I last saw her alive on 2-3, 1921, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard T. Folsom M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Feb 7 1921

20 UNDERTAKER: Margaret G. Flynn ADDRESS: 17 n Eutaw & Light

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1050561

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050561

CERTIFICATE OF DEATH.

REGISTERED NO. C 15-64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Sekellick

(Residence in Baltimore: No. 2810 Walbrook Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec 23, 1839
(Month) (Day) (Year)

7-AGE, 81 yrs. 1 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wm Heidelbel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Augusta Ludwig

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Siebert

(Address) Penna. & Nath. Ave

15-
Filed FEB 6 - 1921 191.. ROBERT J. KRAUSER
REGISTRAR OF VITAL STATISTICS

CAUSE OF DEATH must be plainly stated. Every question must be answered if possible. Unknown or doubtful answers are worse than none. Information is required for the registration of every death and is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 5th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 29 1921, to Feb 5th 1921, that I saw her alive on Feb 4th 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Siebert M. D.

Feb 6th, 1921 (Address) 1720 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Feb 7, 1921

20-UNDERTAKER Wm J. Ecker & Sons

ADDRESS North Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50562 ✓ D50562

CERTIFICATE OF DEATH.

D50562 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marshall M. Caswell Johnson.

(a) RESIDENCE. No. 2426 Barclay ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Keziah P. Johnson

6 DATE OF BIRTH (month, day, and year) Jan 25-1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pension Bureau

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) Northfield Mass.

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northfield Mass.

12 MAIDEN NAME OF MOTHER Frances Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warwick Mass.

14 Informant Chas G. Johnson (Address) Box 125 Pasadena Cal.

15 Filed FEB 6 - 1921 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1920, to February 5, 1921, that I last saw him alive on February 4, 1921, and that death occurred, on the date stated above, at 345 a m.

The CAUSE OF DEATH* was as follows:

Arrio Selerosis.
Chronic Myocarditis
Chronic Diffuse Nephritis
(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & Laboratory

(Signed) Fred J. Bamfield, M. D.

2/5, 1921 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clinton. Mass	Feb 7 1921
20 UNDERTAKER Wm J. Tuckerstons	ADDRESS N Y Pa

N. B. Information should be carefully supplied, so that it may be plain terms, so that it may be CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

650563 HEALTH DEPARTMENT—CITY OF BALTIMORE 650563

CERTIFICATE OF DEATH. 91-061

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3841 Dalrymple Ave ST. 15 WARD)

2-FULL NAME George Irving Graves Jr

(a) RESIDENCE. No. 3841 Dalrymple Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs 7 mos. 3 ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Irving Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Belle C. Wetzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Mrs. Geo I. Graves

(Address) 3841 Dalrymple Ave

15 Filed FEB 6 - 1921 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Feb 4, 1921, that I last saw him alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Toxemia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Fluid Negative

(Signed) W. S. Niblett, M. D.

Feb 4/21 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Feb 7 1921
20 UNDERTAKER	ADDRESS
Wm Tickner & Sons	Norfolk

CAUSE OF DEATH in plain terms. No abbreviations. Omission of any item may delay burial. Information required by law. Please answer every question. Use ink. Write plainly. Do not write on back of certificates. CAUSE OF DEATH is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary Bronchio
Pneumonia — Lobularis
had cleared up entirely.

Spec.—8-24-14—M. & T.—2000 Bks.

D50564 HEALTH DEPARTMENT—CITY OF BALTIMORE D50564

CERTIFICATE OF DEATH.

64 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1569 Richland ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Targarone

(Residence in Baltimore: No. 1569 Richland St that 70 St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 3, 1861 (Month) (Day) (Year)

7-AGE, 60 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman and Shop
(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream

9-BIRTHPLACE, (State or Country), Louisiana

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Isabel Tate

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Targarone

(Address) 1569 Richland St

15-

Filed FEB 6 1921 191.... ROBERT A. KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH in plain terms. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb 5 1921, that I saw him alive on Feb 4 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.1.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) H E Krumbhaar M. D.

Feb 7, 1921 (Address) 1002 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, 2/7/21

20-UNDERTAKER W J Fahnestock & Son

ADDRESS Park & Saratoga

5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1950565

1-PLACE OF DEATH
(a) CITY OF BALTIMORE. (No.) 2089 Woodbery Ave (Ward) 43 an Park Inst
2-FULL NAME Jos A Sawyer
(a) RESIDENCE. (No.) 2089 Woodbery Ave (Ward)
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos.
How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single
If married, widowed, or divorced HUSBAND of (or) WIFE of ✓
DATE OF BIRTH (month, day, and year) Dec 14-1906
AGE Years 14 Months 1 Days 22
If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER W. H Sawyer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa
12 MAIDEN NAME OF MOTHER Agnes Hart
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Sawyer
(Address) 2089 Woodbery Ave

15 Filed FEB 6 1921 ROBERT P. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31st 1921, to Feb 5th 1921,
that I last saw h his alive on Feb 4th 1921,
and that death occurred, on the date stated above, at 4.5 A m.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
Signed H. H. Tillich, M. D.
2/6. 1921 (Address) N. 27 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Feb 19-21

20 UNDERTAKER: Chenowith Son — ADDRESS: Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks. Samuel Brushwilley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50566 D 50566

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Boyd ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Brushwiller

(a) RESIDENCE. NO. 2518 Boyd ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Brushwiller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Brushwiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. Brushwiller
(Address) 2518 Boyd St

15 Filed FEB 6 - 1921 ROBERT B. CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Feb 5, 1921, that I last saw h... alive on Feb 4, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A. Keech, M. D.

2/5, 1921 (Address) Irving Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Feb 7 1921

20 UNDERTAKER Chenowith & Son — ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

050567 HEALTH DEPARTMENT—CITY OF BALTIMORE 050567

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Elliott St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick Wachter

(Residence in Baltimore: No. 3410 — Elliott St.; 1 yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 7 (Month) 3 (Day), 1917. (Year)

7-AGE, 3 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Wachter

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Anna. Dorlfel

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Wachter

(Address) 3410 Elliott St.

15-

Filed FEB 6 1921 ROBERT A KRAUTER REGISTRAR

CAUSE OF DEATH must be plainly written. Every question must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 3 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/4/21 191..., to 2/3/21 191..., that I saw h[illegible] alive on 2/3/21, 191..., and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ....yrs. ....mos. 30 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. McGarrell M. D.

2/3/21, 191... (Address) 633-S-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Feb. 6., 1921.

20-UNDERTAKER Lilly W Fiele ADDRESS 403 S Wolfe St

No other infection prior.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050568

HEALTH DEPARTMENT—CITY OF BALTIMORE

050568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1324 N. Broadway ST. 8 WARD) 115

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmond E. Baroni

(c) RESIDENCE. No. 1324 N. Broadway ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E Baroni

6 DATE OF BIRTH (month, day, and year) June 10 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Baron

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Costello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret E. Baroni

(Address) 1324 N. Broadway

15 Filed FEB 6 1921 ROBERT I. CRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1920, to Feb 4, 1921, that I last saw h[illegible] alive on Feb 3 1921, and that death occurred, on the date stated above, at 3.35 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Kidney -
Immediate Cause
Haemorhage -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. H. Hyatt, M. D.

, 19 (Address) 356 Montgomery St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Feb 7 1921

20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms. Name of disease alone not sufficient. Omit terms "Cause unknown," "Not known," "Not given," "Not stated," "Not ascertained," "Not diagnosed," "Not known if accident, suicide or homicide," "Not known if accident, suicide or homicide," "Not known if accident, suicide or homicide

Dec.—6-9-19—H. P. Co.—1000 Bks.

1050569 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050569

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Streeper ST.: 6 WARD)

2-FULL NAME Daniel A. Capie

(a) RESIDENCE. NO. 405 N. Streeper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Capie

6 DATE OF BIRTH (month, day, and year) Dec 27-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merch't

(b) General nature of industry, business, or establishment in which employed (or employer) 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Robert Capie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Capie
(Address) 405 N. Streeper st

15 FILED FEB 6 - 1921 ROBERT J. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1921, to Dec 3, 1921, that I last saw h[illegible] alive on Dec 3, 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Meyer M. D.

19 (Address) 1111 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Feb 8 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH to be plainly written. See instructions on back of Certificate. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0505 70 HEALTH DEPARTMENT—CITY OF BALTIMORE 0505 70

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Washington ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Scherr

(a) RESIDENCE. NO. 18 N. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Scherr

6 DATE OF BIRTH (month, day, and year) May 15-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Russia

12 MAIDEN NAME OF MOTHER Untarom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 E. Baltimore St.

15 Filed FEB 6 - 1921 ROBERT J. BRAMBLE Registrar

Burial Permit Clerk

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. DICTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1921

17

I HEREBY CERTIFY, That I attended deceased from July 24 1920 to July 5 1920, that I last saw h.. alive on July 5 1920 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) L. Weinstein, M. D.

, 19 (Address) 1340 E. Fund

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Hebrew Cem.	Feb. 6 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

050571 HEALTH DEPARTMENT—CITY OF BALTIMORE 050571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 591-126 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Kastan

(Residence in Baltimore: No. 1435 E. Fayette st. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1844 (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Peddler
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis = Jacob Katan

(Address) 1411 E Balt St

15-FEB 6 - 1921 Filed, 191 ROBERT E. LAZISTER Registrar

Burial Permit Issued

N. B.—CAUSE OF DEATH in plain terms is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 5 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 30 1921, to February 5 1921, that I saw h[illegible] alive on February 5 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Postoperative)

(Duration) 1 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Postatic Hypostatic Pneumonia

(Duration) yrs. mos. ds.

(Signed) Louis Sachs M. D.

Feb. 5, 1921. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 25 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1435 E Balt St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 2-6, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

050572 HEALTH DEPARTMENT—CITY OF BALTIMORE 050572

175-001

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No..... General Hospital. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Paul.

(Residence in Baltimore: No. 3447 Cedar Ave. St.: 2 yrs., 3 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, October 26th, 1918, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
2 yrs. 3 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Leon Paul.

11-BIRTHPLACE OF FATHER (State or Country). Russia.

12-MAIDEN NAME OF MOTHER Mollie Kairys.

13-BIRTHPLACE OF MOTHER (State or Country). Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Paul. (father)

(Address) 3447 Cedar Ave

15- Filed FEB 6 - 1921 1921 BOARD & LAWTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 3rd, 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull

Automobile accident

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

Feb. 4th, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Hanover & Ostend Sts.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 2/6 19..

20-UNDERTAKER Jack Levis

ADDRESS 1411 E Balt St

N. B.—Every item of CAUSE OF DEATH in plain terms, as correct and complete as possible, is important. See instructions on back of certificate.

Amanda E. Grace

Spec.—8-24-14—M. & T.—2000 Bks.

950573

HEALTH DEPARTMENT—CITY OF BALTIMORE

950573

CERTIFICATE OF DEATH.

REGISTERED NO. C 66

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Amanda E Grace ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1923 McCulloh St

(Residence in Baltimore: No. 1923 McCulloh St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., 1857 (Month) (Day) (Year)

7-AGE 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Jonas Hooper

11-BIRTHPLACE OF FATHER (State or Country), Fredinh

12-MAIDEN NAME OF MOTHER Mary Hooper

13-BIRTHPLACE OF MOTHER (State or Country). Penn., D.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Grace Johnson

(Address) 1923 McCulloh St

15- Filed FEB 6 - 1921 191... ROBERT B. LAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH. This line must be filled out. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan. 31 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 31 1921 to Feb. 3d 1921, that I saw him alive on Feb 3d 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemoplegia

OVER

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of arteries

(Duration) yrs. mos. ds.

(Signed) A. E. Zeller M. D.

, 1921 (Address) 92 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery

DATE OF BURIAL, Feb 6, 1921.

20-UNDERTAKER John H Todd

ADDRESS 142 White St

No terminal hemorrhage. Not apoplectic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050574 HEALTH DEPARTMENT—CITY OF BALTIMORE 050574

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1915 W. Franklin St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Guthrie Wescott

(a) RESIDENCE. NO. 1915 W. Franklin St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Wescott

6 DATE OF BIRTH (month, day, and year) Aug. 26" 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	73	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Merchants & Miners

(c) Name of employer Transportation Co.

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Harriet Guthrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ---- England

14 Informant Mrs. Mary E. Wescott
(Address) 1915 W. Franklin St.

15 FILED FEB 6 1921 ROBERT A. FEATHER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5" 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1920, to Feb 5, 1921, that I last saw him alive on Feb 4, 1921, and that death occurred, on the date stated above, at 6 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage.

Suddenly - about

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteria Sclerosis, 15 min

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Palpation of Arteries

(Signed) Nancy E. Cole, M. D.

Feb 5. 1921 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 8 1921
20 UNDERTAKER Joseph B. Cole	ADDRESS 1003 Pales St

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See information on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050575 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 050575

CERTIFICATE OF DEATH.

8 92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1821 No. Caroline St. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Gerlach

(a) RESIDENCE. No. 1821 No. Caroline St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Gerlach

6 DATE OF BIRTH (month, day, and year) June 22" 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fenge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kathryn E. Muldner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. William Gerlach (Address) 1821 No. Caroline St.

15 Filed FEB 6 1921 ROBERT P. BRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH in plain ... TION is very important. See instructions on ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4" 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1921, to Feb. 4th, 1921, that I last saw her alive on Feb 4th, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm Pearle, M. D.

2-4 , 192 (Address) 1 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 7 19
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

050576 HEALTH DEPARTMENT—CITY OF BALTIMORE 050576

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn V. Wessels

(a) RESIDENCE. NO. 1614 W. Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Wessels

6 DATE OF BIRTH (month, day, and year): Nov 22 1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Alfred Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Ida Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Harry E. Wessels 1614 W Baltimore

15 Filed FEB 6 1921 ROBERT N. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 5 1921

17

I HEREBY CERTIFY, That I attended deceased from December 13, 1921, to Feb. 5, 1921, that I last saw her alive on February 5, 1921, and that death occurred, on the date stated above, at 3.05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical & pathological laboratory findings

What test confirmed diagnosis?

(Signed) L. S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 8 19 21
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1003 W Balto St

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050577

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050577

CERTIFICATE OF DEATH.

120-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3033 Windsor Ave, ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lee Smith

(a) RESIDENCE. No. 3033 Windsor Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. C. Smith

6 DATE OF BIRTH (month, day, and year) May 16" 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
82	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Culpeper Va.

PARENTS

10 NAME OF FATHER: Jesse Lee Burrows

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgetown D. C.

12 MAIDEN NAME OF MOTHER: Catherine T. Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Layton F. Smith
(Address) 300 E. 30th St.

15 Filed FEB 6 - 1921 ROBERT J. BRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 4" 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 30 1921 to Feb. 4 1921, that I last saw h.. alive on Feb. 4 1921, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (secondary) Chronic Nephritis & arterio-Sclerosis (duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Chest Examination

(Signed) D A Dodds, M. D.

Feb. 4 1921 (Address) 3101 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 7 1921

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W Balto St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

145926
2050578

2050578

CERTIFICATE OF DEATH.

30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Inez Yates.

(a) RESIDENCE. NO. 1204 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Vincent Lewis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgianna Yates

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J. H. Hospital records
(Address)

15 Filed FEB 6 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4- 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to 2-7, 1921, that I last saw her alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 1205 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. mos. 12 (?) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tubercule bacilli in special fluid

(Signed) Horton Casparis, M. D.

2-4, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Albury Cemetery	Feb. 6 1921
20 UNDERTAKER	**ADDRESS**
Milton Davis.	413 N. Eden St

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

050579 HEALTH DEPARTMENT—CITY OF BALTIMORE 050579

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 110 S Schroder ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E McHugh

(a) RESIDENCE. No. 111 S Schroder ST., 18 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ (or) WIFE of James McHugh

6 DATE OF BIRTH (month, day, and year) Dec 23-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER John Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs J. Tierney
(Address) 111 S Schroeder

15 Date received FEB 6 1921 REGISTRAR
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15. 1921, to Feb. 4, 1921, that I last saw h~~e~~r alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

3 mos under my care
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis. B.P. etc

(Signed) F. C. Bound, M. D.

2-4, 1921 (Address) 904 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	2-7-1921
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Indefinite terms, such as "Heart Disease," "Cancer," "Tumor," "Abscess," "Paralysis," "Convulsions," "Old Age," "Senility," "Infirmities of Age," "Debility," "Exhaustion," "Childbirth," "Accident," "Fracture," "Injury," "Drowning," "Burns," "Scalds," "Asphyxia," "Poisoning," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Hemorrhage," "Suppression," "Ulceration," "Inflammation," "Fever," "Malignant Disease," "Tuberculosis," "Consumption," "Pneumonia," "Bronchitis," "Pleurisy," "Nephritis," "Kidney Disease," "Liver Disease," "Gastritis," "Enteritis," "Colitis," "Peritonitis," "Appendicitis," "Hernia," "Obstruction," "Stricture," "Perforation," "Rupture," "Aneurism," "Thrombosis," "Embolism," "Endocarditis," "Pericarditis," "Myocarditis," "Valvular Disease," "Arteriosclerosis," "Cerebral Hemorrhage," "Cerebral Embolism," "Cerebral Thrombosis," "Cerebral Softening," "Cerebral Abscess," "Cerebral Meningitis," "Cerebral Tumor," "Cerebral Paralysis," "Cerebral Congestion," "Cerebral Anemia," "Cerebral Hyperemia," "Cerebral Edema," "Cerebral Apoplexy," "Cerebral Hemiplegia," "Cerebral Monoplegia," "Cerebral Diplegia," "Cerebral Quadriplegia," "Cerebral Hemiparesis," "Cerebral Monoparesis," "Cerebral Diparesis," "Cerebral Quadriparesis," "Cerebral Hemiataxia," "Cerebral Monoataxia," "Cerebral Diataxia," "Cerebral Quadriataxia

Spec.—8-24-14—M. & T.—2000 Bks.

Scheib

1950580 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1950580

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Ave Lakeland 25 St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lillian Anna Scheib

(Residence in Baltimore: No. Belvedere Ave., Lakeland St.; 72 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan. (Month) 14 (Day), 1859 (Year)

7-AGE, 61 yrs. 11 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Lancaster Pa.

PARENTS.

10-NAME OF FATHER, Joseph Larner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Bauman

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Scheib Sr.

(Address) Belvedere Ave. Lakeland

15- Filed FEB 6 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

CAUSE OF DEATH is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921, to Feb 4 1921, that I saw h[illegible] alive on Feb 4 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 7 yrs. ... mos. ... ds.

(Signed) H. Laurence Wheeler M. D.

....., 191... (Address) Lakeland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Feb. 7, 1921
20-UNDERTAKER H. C. Brauning Son	ADDRESS 517 N. Belvedere St

Spec.—6-9-19—H. P. Co.—1000 Bks.

050581 HEALTH DEPARTMENT—CITY OF BALTIMORE 050581

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Willow Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Merchant

(a) RESIDENCE. No. 615 Willow Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George E. Merchant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Hannah K Younger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George E Merchant
(Address) 615 Willow Ave

15 Filed FEB 7 1921 ROBERT P. PRUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 6, 1921, that I last saw him alive on Feb 6, 1921, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Membranous Croup

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Schaefer, M. D.

, 19 (Address) 53 S. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bal Cem	Feb 7 1921
20 UNDERTAKER	ADDRESS
Wm Carter	502 E Pratt

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

050582 Printy

HEALTH DEPARTMENT—CITY OF BALTIMORE

050582

CERTIFICATE OF DEATH.

REGISTERED No. C 103

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2018 E Hoffman St.; 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Printy
(Residence in Baltimore: No. 2018 E. Hoffman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, N

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH: Feb. (Month) 15 (Day), 1852 (Year)

7-AGE 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): — D 86

9-BIRTHPLACE, (State or Country) Baltimore.

PARENTS.
10-NAME OF FATHER, John Printy
11-BIRTHPLACE OF FATHER (State or Country), Ireland.
12-MAIDEN NAME OF MOTHER, Catherine Brady
13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. J. Scallen
(Address) 2018 E. Hoffman

15- Filed FEB 7 - 1921, 19[illegible] ROBERT B. KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows:
Ac Indigestion
(Duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. ds.
(Signed) Geo. C. Brady M. D.
2/6/21 (Coroner)
(Address) 743 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, 2/8, 1921

20-UNDERTAKER Wm Cook — ADDRESS 502 E Nor

N. B. CAUSE OF DEATH in plain terms. See instructions on back of certificate.

from overeating Fried Potatoes & Pork
seemed to ask before my attack.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050583

HEALTH DEPARTMENT—CITY OF BALTIMORE

050583

CERTIFICATE OF DEATH.

108-091

REGISTERED NO.....

1-PLACE OF DEATH Union Memorial Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mr. Sam Siegel

(a) RESIDENCE. NO. Bainbridge Ga ST.. WARD. Bainbridge, Georgia.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Sam Siegel

6 DATE OF BIRTH (month, day, and year) August 12th, 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Isaac Siegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant (Address) Jack Lewis 1411 E Balto St

15 Filed FEB 7 1921 ROBERT B KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 24th, 1921, to February 4th, 1921, that I last saw him alive on February 4th, 1921, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal adhesions

Chronic appendicitis

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Intestinal obstruction 2 mos. 6 ds. / Broncho-pneumonia 1 ds.

(duration) yrs.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes. Date of Jan 31st, 1921.

Was there an autopsy? no

What test confirmed diagnosis? Operation + clinical course

(Signed) J. M. V. Hannery M. D.

Feb 4th 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark N.J. DATE OF BURIAL 2/7 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50584 ✓ D50584

91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 Fort Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. E. Brigerman.

(a) RESIDENCE. NO. 1438 Fort Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 16. 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Milton E. Brigerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Bertha A. Rankin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md

14 Informant Milton E. Brigerman.
(Address) 1438 Fort

15 Filed FEB 7 - 1921 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to Feb. 5, 1921, that I last saw h— alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

2/6, 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	2/7 1921
20 UNDERTAKER	ADDRESS
John Baker Sons	318 Light St

CAUSE OF DEATH in plain ... See instructions on back of certificate. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* **The nature of the injury,** as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Started as a bronchitis.

Rec.—6-9-19—H. P. Co.—1000 Bks.

050585 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 050585

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 501 N. Montford Ave ST.: 7 WARD)

REGISTERED No. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie M. Triolo

(a) RESIDENCE. No. 501 N. Montford av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1yr. yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Triolo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bernard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Anna Triolo
(Address) 501 N. Montford Ave.

15 Filed FEB 7 - 1921 BOWEN E KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH must be plainly stated. See instructions on back OF CERTIFICATE. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to Feb 4, 1921,
that I last saw h.. alive on Feb 4, 1921
and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) 7 Fred Rus Lee M. D.

2-5, 1921 (Address) 808 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 7th 1921

20 UNDERTAKER Geo C. Miller ADDRESS 2334 Jefferson

Spec.—8-24-14—M. & T.—2000 Blks.

D50586 HEALTH DEPARTMENT—CITY OF BALTIMORE D50586

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 N Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Tyler

(Residence in Baltimore: No. 533 N Chester St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, July 4 (Month), (Day), 1921 (Year)

7-AGE, ...yrs. ....mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Tyler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Selma D. Coleman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. William Tyler

(Address) 533 N. Chester Ave

15- FEB 7 - 1921 Filed....., 191... ROBERT F. BRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 6 1921, that I saw her alive on July 5 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Premature Labor at 7½ months

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Rudolph LeRosenberg M. D.

July 6, 1921 (Address) 201 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Carmel Cemetery | DATE OF BURIAL, Feb 7, 1921

20-UNDERTAKER William G. Schaffer | ADDRESS 1116 Eastern Ave

CAUSE OF DEATH must be stated in plain English. Every question must be answered if possible. Physician must sign certificate. Undertaker must file certificate. Both are liable to penalty for neglect of duty. See instructions on back of certificate. Read carefully. Every statement must be full and complete. Every question must be answered if important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1950587 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950587

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St.: 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stokley Baker

(a) RESIDENCE. No. 115 S Carrollton Ave Ward.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Ross

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Annie Baker
(Address) 115 S Carrollton Ave

15 Filed FEB 7 - 1921 ROBERT P. KRAUTER Registrar
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1921

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1921, to February 5, 1921.

that I last saw him alive on February 5, 1921.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman

(Signed) Wm Francis Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 8 1921

20 UNDERTAKER John Feith ADDRESS 1200 W Lombard

CAUSE OF DEATH to be written in ink. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

050588 050588

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 West ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis J. McElgunn

(a) RESIDENCE. NO. 1136 West ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Owen McElgunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary M. Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret McElgunn

(Address) 1136 W Pratt

15 Filed FEB 7 - 1921 19 ROBERT J. KNAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5/1921

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1921, to 2/5, 1921, that I last saw h— alive on 2/4/, 1921, and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Hist yrs. 13 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Barnard J. Tenny, M. D.

2/6, 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL 2/7 1921

20 UNDERTAKER Wm Staub ADDRESS 1200 W Lombard

CAUSE OF DEATH IN plain ... See instructions on back of ... TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Baby Moran

HEALTH DEPARTMENT—CITY OF BALTIMORE

2050589 2050589

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Hoyt St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Moran

(a) RESIDENCE. NO. 1611 Hoyt St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Helen Moran~~

6 DATE OF BIRTH (month, day, and year) 1/17/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - Obv

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER William Moran

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Edna Smith

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Moran (Address) 1611 Hoyt St. ~~Washington~~

15 Filed FEB 7 - 1921, 19 ROBERT A. LUCKETT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/1921

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 1921, to 2/6, 1921, that I last saw h- alive on 2/6, 1921, and that death occurred, on the date stated above, at 6.00 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth (Twin)

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatum

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. D. Kelly, M. D.

2/6, 1921 (Address) 1611 Hoyt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feby 8 1921

20 UNDERTAKER ADDRESS

J O Mitchell 1201 W Fayette St

CAUSE OF DEATH must be given in plain English. See instructions on back of Certificate. ATTENTION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

050590

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 050590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hollie Hall

(a) RESIDENCE. No. 906 Rutland ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Hall

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Henry Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Cornelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 FEB 7 - 1921 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Feb. 5, 1921, that I last saw her alive on Feb. 5, 1921, and that death occurred, on the date stated above, at 9.07 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) L. S. Falmdisch, M. D.

2-5-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Goldsboro N.C.	Feb 7 1921
20 UNDERTAKER Mrs Rolta Elliott	ADDRESS 725 Rutland ave

CAUSE OF DEATH ON BACK OF CERTIFICATE. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050541 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 McCulloh St.; 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lethia Lawton

(a) RESIDENCE. No. 1021 McCulloh St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lawton

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years: 53 yrs | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: cook 021

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Richard Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Christie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: John Lawton (Address) 1031 McCulloh St

15 Filed FEB 7 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1921, to Feb 5, 1921, that I last saw her alive on Feb 4, 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.,

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Examination of Sputum

(Signed) Wm. V. Fitzgerald, M. D.

2/6. 1921 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery | DATE OF BURIAL: Feb 7 1921

20 UNDERTAKER: Mrs Robt Elliott | ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms. See instructions on back. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stein

050592 HEALTH DEPARTMENT—CITY OF BALTIMORE 050592

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 710 Portland ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha B. Stein

(a) RESIDENCE. No. 710 Portland ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles H. Stein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Pa

PARENTS

10 NAME OF FATHER Mathias Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Pa

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Pa

14 Informant Charles Stein
(Address) 710 Portland St

15 Filed FEB 7 - 1921 19 ROBERT B KRAUSER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Feb 4, 1921, that I last saw h. alive on Feb 3, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

2-6, 1921 (Address) 602 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 7th 1921
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 W Balto

N. B.—WRITE PLAINLY, with pen and ink. All items must be properly classified. Age should be carefully supplied. Any information should be carefully supplied. Age should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

050593 HEALTH DEPARTMENT—CITY OF BALTIMORE 050593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2 Lorraine Ave. Ward 8) REGISTERED No. C 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris C Maurand

(Residence in Baltimore: No. 2733 Preston St. Wh. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F | 4-COLOR OR RACE, W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Nov 25, 1914 (Month) (Day) (Year)

7-AGE, 6 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ppd
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo A Maurand

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Catherine Smith

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo A Maurand

(Address) 2733 Preston St

15- Filed FEB 7 1921, 191.. ROBERT J. KRAUTER Registrar. Burial Permit Issued

N. B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feby 5, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dyspnea, due to
chronic pleurisy
Blood (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Feb 7, 1921. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dallstown Cem | DATE OF BURIAL, Feby 7, 1921

20-UNDERTAKER Robt J Turner | ADDRESS 1472 N Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050594 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050594

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4764 Pimlico Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williamanna Leake

(a) RESIDENCE. NO. 4764 Pimlico Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Joseph M. Leake

6 DATE OF BIRTH (month, day, and year) Oct. 21. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home Job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Stansbury

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Busby

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Saml. C. Stewart
(Address) 4764 Pimlico Road

15 Filed FEB 7 - 1921 [illegible] Registrar

Burial Permit Given

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 6 1921

17 I HEREBY CERTIFY, ~~That~~ I attended deceased from Jan 30, 1921, to Feb 5, 1921, that I last saw h[illegible] alive on Feb 5, 1921, and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Wm D. Bubert, M. D.

Feb 5, 1921 (Address) 1857 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem Co	Feby 7 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1948 W. North Av

Spec.—8-24-14—M. & T.—2000 Bks.

050595 HEALTH DEPARTMENT—CITY OF BALTIMORE 050595

CERTIFICATE OF DEATH.

91-089

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred W. Klein

(Residence in Baltimore: No. 218 S. Bond St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 3, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edward W. Klein

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mamie K Davis

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie K. Klein

(Address) 218 S. Bond St

15- FEB 7 - 1921 ROBERT P. KRAUTER

Filed ..... 191.... Burial Permit Clerk
Registrar.

CAUSE OF DEATH. This line must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Feb 6 1921, that I saw h[illegible]alive on Feb 6 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Nathan J. Davidow M. D.

Feb. 6..., 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 218 S. Bond St.

Former or usual residence 218 S Bond St.

19-PLACE OF BURIAL, OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, Feb. 9..., 1921

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Eden St.

e. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 250596 250596

CERTIFICATE OF DEATH

91

1-PLACE OF DEATH St agnes Hospital

CITY OF BALTIMORE: (No. St. Agnes Hosp ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Chas. E. Barnes

(a) RESIDENCE. No. 405 Greenmount Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Ruby A. Barnes

6 DATE OF BIRTH (month, day, and year) Oct, 1, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real estate broker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Hanson P. Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cumberland Maryland

12 MAIDEN NAME OF MOTHER: Catherine A Weyrauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: William R. Barnes

(Address): 2929 Guilford Ave.

15 Filed FEB 7 - 1921 19 ROBERT I. LEAUTER Registrar

Burial Permit Given

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5. 1921 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4th, 19 21, to Feb 5th, 19 21, that I last saw h[illegible] alive on Feb 5th, 19 21, and that death occurred, on the date stated above, at 7.55 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. E. Chas, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetary	2-7-21 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

050697 HEALTH DEPARTMENT—CITY OF BALTIMORE 050597

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1111 Binney ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Raymond Baudt

(a) RESIDENCE. No. 1111 Binney ST., 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 4 mo

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John J. Baudt

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary A Finnerty

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant John J. Baudt
(Address) 1108 Binney St.

15 Filed FEB 7 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to Feb 6, 1921, that I last saw him alive on Feb 5, 1921, and that death occurred, on the date stated above, at 6 00 a. m.

The CAUSE OF DEATH* was as follows:

exhaustion

(mother died of Pulmonary Tuberculosis several days previously to date.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis - general insanity not fed. (duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. M. Magruder, M. D.

2/6, 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethlehem Cemetery	Feb 7 1921

20 UNDERTAKER	ADDRESS
Lilly + Jeiler	400 N. Norfolk

CAUSE OF DEATH must be given. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

950598 HEALTH DEPARTMENT—CITY OF BALTIMORE 950598

CERTIFICATE OF DEATH.

91 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 N. Calvert ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan A. Moxley

(Residence in Baltimore: No. 701. N Calvert St.; 70 yrs., 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Woman	White	Widow

6-DATE OF BIRTH, May 19, 1844 (Month) (Day) (Year)

7-AGE, 71 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Enos Bussard

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan A. Bussard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Grant Brown

(Address) 701 N. Calvert St.

15 FEB 7 - 1921 Filed.....

ROBERT B KRAUTER Registrar

CAUSE OF DEATH. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 5, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1921, to Feb 5th 1921, that I saw h[er] alive on Feb 5th 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Phaeochrom

(Duration) Prostate yrs. ....mos. ....ds.

(Signed) ..... M. D.

Feb 6, 1921. (Address) 607 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Montgomery Cem. Co.

DATE OF BURIAL, Feb 7, 1921

20-UNDERTAKER E J B Haile

ADDRESS 115 East Balto

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050599

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050599

CERTIFICATE OF DEATH.

130

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Gough Street ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARYANNA WESOLOWSKI

(a) RESIDENCE. NO. 1820 Gough Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of JOSEPH WESOLOWSKI

6 DATE OF BIRTH (month, day, and year) Oct 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER JOSEPH JAKUBIAK

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant (Address) Joseph Wesolawski 1820 Gough St

15 Filed FEB 7 - 1921 Burial Permit Issued by ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3rd, 1921, to Feb. 5th, 1921, that I last saw her alive on Feb. 5th, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Singwald, M. D.

2/6, 1921 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 8 1921

20 UNDERTAKER John M. deBeer ADDRESS 1803 Bank St

CAUSE OF DEATH. See instructions on back of this CERTIFICATE. IMPORTANT. See instructions on back of this CERTIFICATE. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050600 ✓ L050600

CERTIFICATE OF DEATH.

120 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanitorium ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Elizabeth Krebs.

(a) RESIDENCE. No. Edgewood Sanitorium ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred? Life How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced (or) WIFE of George W. C. Krebs Deceased

6 DATE OF BIRTH (month, day, and year) Aug 21 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emily E Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Miss Sallie Sewell (Address) 1037 W. Fayette St

15 Filed FEB 7 - 1921 ROBERT R KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1921, to Feb. 5, 1921, that I last saw h.. alive on Feb. 5, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Vol Hoen, M. D.

(Address) 5600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feby 7 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W North ave

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

050601 050601

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37-09

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 N. Kenwood Ave ST. | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew F Valentine

(a) RESIDENCE. No. 539 N Kenwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M Valentine

6 DATE OF BIRTH (month, day, and year) Oct 2 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Woodall Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John P. H. Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Annie M.E. Wehrhahn

(Address) 539 N Kenwood Ave.

15 FEB 7 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from January 29 1921, to Feb. 3, 1921, that I last saw him alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Otis

Lobar Pneumonia

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Locomotor Ataxia (duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Sandrock M. D.

2. 4. 1921 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	FEB 7 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST

CAUSE OF DEATH ... TION is very important. See instructions on back

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Suicide.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50602 HEALTH DEPARTMENT—CITY OF BALTIMORE D50602

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2737 Bernard ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ellis Cross

(a) RESIDENCE. No. 2737 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kezia L. Cross

6 DATE OF BIRTH (month, day, and year) Feb. 2. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer Gallinger Baltimore, Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John L. Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Negordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Kezia L Cross

(Address) 2737 Bernard St

15 FEB 7 1927 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1927, to Feb 5, 1927, that I last saw h[illegible] alive on Feb 4. 1927, and that death occurred, on the date stated above, at 10:10 9 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart disease (Mitral) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) H Arthur Darby, M. D.

, 19 (Address) 1611 Lexington Ave, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's	Feb 7/27

20 UNDERTAKER A S Marshall ADDRESS 3539 Fait Ave

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150603 150603 91 150603 REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Glen Edwards Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelina Venance

(Residence in Baltimore: No. 407 Glen Edwards Ave St.; ....yrs., 5 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 3rd (Day), 1920 (Year)

7-AGE, ...yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....None....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Venance

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Rosarie Gennaro

13-BIRTHPLACE OF MOTHER (State or Country). Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Venance

(Address) 407 Glen Edward Ave.

15- FEB 7 - 1921 ROBERT A KRAUTER

Filed ....., 191.... Burial Permit Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 6th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 5th 1921 to Feb. 6th 1921, that I saw h.. alive on Feb 6th 1921, and that death occurred, on the date stated above, at 10.15a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Not known

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY. Exhaustion

(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. H. Cross M. D.

Feb 6th, 1921. (Address) 2409 Mid Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents DATE OF BURIAL, Feb ....., 191..

20-UNDERTAKER A.S. Marshall ADDRESS 3539 Fall Rd

CROSS OUT words not important. See instructions on back of certificate.

No history of any other infection.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engincer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housckeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pncumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

650604 650604 92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E. Cross ST.: 24 WARD)

2-FULL NAME James J. Jenkins

(a) RESIDENCE. No. 117 E. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of France Jenkins

6 DATE OF BIRTH (month, day, and year) Oct 14 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66 Years	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Cleaning Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Humberland County, Virginia

PARENTS

10 NAME OF FATHER Wm. Giles Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Humberland Co. Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Jenkins (Address) 117 E. Cross St

15 Filed FEB 7 - 1921 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH ... TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 22, 1921, to Feby 5, 1921, that I last saw him alive on Feby 5, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Bacteriological

(Signed) W. D. Daniels, M. D.

Feby 6, 1921 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 8 1921
20 UNDERTAKER	ADDRESS
F. A. Hausner Son	703 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

050605 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 050605

CERTIFICATE OF DEATH. 154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Monroe ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Michael

(a) RESIDENCE. NO. 1117 N. Monroe ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Leonora Michael

6 DATE OF BIRTH (month, day, and year) June 2nd 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Ret. Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Genl. Merchandise

(c) Name of employer ~~Store~~ in Oakland Md.

9 BIRTHPLACE (city or town) (State or country) Jefferson York Co Pa.

PARENTS

10 NAME OF FATHER Jacob Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elz. O'Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Nettie M. Stoddard (Address) 333 Presstman St

15 Filed FEB 7 - 1921 ROBERT I. LEADER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to Feby 5, 1921, that I last saw h~~im~~ alive on Feby 4, 1921, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Gradual Weakening & Inability to take nourishment old age & arterial sclerosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) No disease apparent (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed Smith, M. D.

Feby 5 1921 (Address) 1625 W. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 8 1921

20 UNDERTAKER ADDRESS

Josiah Sy for 1606 W North Av

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

950606 950606 950606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital St.; 14 WARD) REGISTERED NO. C 740

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Zola May Davis.

(Residence in Baltimore: No. Womans Hospital St.; —yrs., —mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 31 (Month) (Day), 1871 (Year)

7-AGE, 49 yrs. 0 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country): Martinsville, Va.

PARENTS.

10-NAME OF FATHER. George F Davies.

11-BIRTHPLACE OF FATHER (State or Country), Martinsville Va.

12-MAIDEN NAME OF MOTHER Martha J. Davis.

13-BIRTHPLACE OF MOTHER (State or Country), Martinsville.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Davis

(Address) Martinsville Va

15- FEB 7 - 1921 Filed ROBERT A KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to Feb 6 1921, that I saw her alive on Feb 6 1921, and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition not known

(Duration) yrs. mos. ds.

(Signed) Frank DeWaltington M. D.

Feb 7, 1921. (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death —yrs. —mos. 11 ds. In the State —yrs. —mos. 11 ds.

Where was disease contracted, if not at place of death? Martinsville Va

Former or usual residence Martinsville Va.

19-PLACE OF BURIAL OR REMOVAL, Martinsville Va. DATE OF BURIAL, Feb 7, 1921

20-UNDERTAKER Chas E. Evans & Son ADDRESS 118 West Royal Ave

CAUSE OF DEATH. See instructions on back of certificate important.

Spec.—8-24-14—M. & T.—2000 Bks.

50607

HEALTH DEPARTMENT—CITY OF BALTIMORE

50607

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521- E-20 th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas M. Kelly.

(Residence in Baltimore: No. 521- E-20th St.; 52 yrs., 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 26, 1864
(Month) (Day) (Year)

7-AGE, 52 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... G.E.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Brien

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edw. Smith

(Address) 521 E 20 th St.

15- FEB 7 - 1921 Filed....., 191.... ROBERT J. BRAUTIGAM Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 6th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 22 1921, to Feby 5th 1921, that I saw him alive on Feby 5th 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Knight Forsythe M. D.

Feby 7, 1921. (Address) 424 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb 8, 1921.

20-UNDERTAKER H. W. Caulfield & Boyd Bros

ADDRESS 624 W Fayette

CAUSE OF DEATH. See instructions on back of certificate. Items are important.

pec.—6-9-19—H. P. Co.—1000 Eks.

050608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 v 050608

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 304 Harwood Ave. St.: 12 Ward)

2-FULL NAME Mary Hills.

(a) RESIDENCE. No. 304 Harwood Ave St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther Hills

6 DATE OF BIRTH (month, day, and year) Jan 4 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nicholas Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Cath Baisdell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant (Address) Mrs. S. Merryman 304 Harwood St

15 Filed FEB 7 - 1921 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to Feb 4, 1921, that I last saw h[illegible] alive on Feb 4, 1921, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Syncitical Gangrene (Raynaud's) both hands (duration) ? yrs. mos. 7 ds. Chronic Nephritis

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs only

(Signed) Wm H Forsaith, M. D.

, 19 (Address) 703 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 8 1921

20 UNDERTAKER E A Weedfield Jr — ADDRESS 501 E 22

CAUSE OF DEATH [illegible] TION is very important. See instructions on

50609

50609

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92-120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Forrest ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kavanaugh

(a) RESIDENCE. No. 817 Forrest ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

086

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Matthew Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Looney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

11 Informant: Gillian McKee
(Address) 817 Forrest St

15 Filed FEB 7 - 1921 ROBERT J. BRAUTER Registrar

CAUSE OF DEATH to be plainly written. PHYSICIAN is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1921, to Feby 6, 1921, that I last saw h[er] alive on Feby 6, 1921, and that death occurred, on the date stated above, at 12.50 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. G. Hornstein, M. D.

2/7, 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Feb 9 19[illegible]

20 UNDERTAKER: Wm. H. Forbes & Son ADDRESS 827 W. Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50610

CERTIFICATE OF DEATH.

15 50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Baker ST.; 15 WARD)

2-FULL NAME Philip E McEnaney

(a) RESIDENCE. No. 1619 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McEnaney

6 DATE OF BIRTH (month, day, and year) June 22 1855

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer American Cigar Co

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Owen McEnaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary McEnaney
(Address) 1619 Baker St

15 Filed FEB 6, 1921 ROBERT B. KRAUTER Registrar

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN. TION is very important. See instructions on back of cer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1920 to Feb 3 1921, that I last saw him alive on Feb 3 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? X

(Signed) J. E. Schmuck M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Feb 8 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

992 D 50611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S Castel ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wimmer

(a) RESIDENCE. NO. 27 S Castel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Monica Selner

6 DATE OF BIRTH (month, day, and year) Feb 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 614

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Reuses + Company

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Monica Wimmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Strunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Monica Wimmer (Address) 27 S Castel

15 Filed FEB 7 - 1921 ROBERT J. BRAGER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1921, to February 4, 1921, that I last saw him alive on February 3, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Toxemia - Eruption - Myocarditis

arteriosclerosis - Senility

(duration) ..... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypertrophia cordis

(duration) ..... yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H. Schwartz, M. D.

2/6, 1921 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 8 1921
20 UNDERTAKER	ADDRESS
Wendell Ruffel & Son	37 S Ann

CAUSE OF DEATH. Please read carefully the rules on back of certificate. ANSWER EACH QUESTION IN FULL. Use both sides of this TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

50612 50612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Eden ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Westkamp

(a) RESIDENCE. NO. 16 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Westkamp

6 DATE OF BIRTH (month, day, and year) June 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Staunton
(State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mr. Agnes Westkamp
(Address) 16 N. Eden st.

15 Filed FEB 7 - 1921 19 ROBERT A. LAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Feb 4, 1921, that I last saw h in alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam of urine

(Signed) Capt J. Green, M. D.

2-4-1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Feb. 8 1921
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Luzerne ave.

CAUSE OF DEATH must be given in plain English. See instructions on back of certificate. ATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Swickle

HEALTH DEPARTMENT—CITY OF BALTIMORE

650613

650613

91-089

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N Glover ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmira Swickle

(Residence in Baltimore: No. 714 N Glover St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March (Month) 31 (Day), 1919 (Year)

7-AGE, 1 yrs. 10 mos. ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Edgar Swickle

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Barbara Flanigals

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Swickle

(Address) 714 N Glover St

15- FEB 7 - 1921 Filed....., 191... ROBERT J. KRAUTER Registrar. Burial Permit.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 20 1921, to February 5th 1921, that I saw her alive on February 5th 1921, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Profound Toxemia Cardiac failure.

(Duration).....yrs.....mos.....ds.

(Signed) Cornelius E. Lutz M. D.

February 7, 191... (Address) 1210 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	Feb 8, 1921
20-UNDERTAKER Finet & Enoch Sons	ADDRESS 1906 Park Ave

Cross out words not important. See instructions on back of certificate.

D. 50614 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 613 Cider alley St.: 4 WARD) REGISTERED No. C 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H Bell

(Residence in Baltimore: No. 613 Cider alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1883 (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, Geo Bell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Garrison

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie Bell

(Address) 613 Cider Alley

15- Robert P. Harrison, Registrar.

FEB 7 1921 19.. Burial Permit Clerk.

NOTE.—Every item of DEATH in plain terms, so that it may be understood. CAUSE OF DEATH important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~the~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know any

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M K Gorsuch M. D. (Coroner.)

2-6, 1921 (Address) 117 N Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb 8th 1921

20-UNDERTAKER Samuel L Wyatt

ADDRESS 1364 W Pratt

Spec.—6-9-19—H. P. Co.—1000 Blks.

10.50615

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.50615

131

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Church Home Hosp ST.: 8 WARD)

2-FULL NAME Hida M. Bowers.

(a) RESIDENCE. NO. Berkshire Road Arcadia WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry B. Bowers

6 DATE OF BIRTH (month, day, and year) Feb. 2 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Marks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Ellen Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Harry B. Bowers

(Address) ~~Robert P. Harrison,~~

15 Filed ..... 19 ..... Registrar

FEB 7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb ✓ 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb ✓ 1921, that I last saw h alive on Feb ✓ 1921, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ✓ ds.

CONTRIBUTORY (Secondary) Ovarian Cyst.

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 5-1921

Was there an autopsy? No

What test confirmed diagnosis? Physicis Exam. Operation

(Signed) Richard G. Corbett M. D.

, 19 (Address) Church Home & Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 8 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

20.50616

HEALTH DEPARTMENT--CITY OF BALTIMORE

20.50616

CERTIFICATE OF DEATH

142

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3133 E. Baltimore ST.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lizella A. Lewis

(Residence in Baltimore: No. 3133 E. Baltimore St.: Life yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan. (Month) 5 (Day), 1841 (Year)

7 AGE: 80 yrs. 1 mos. .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): do

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Andrew B. Lewis

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Harriet A. Shinnick

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alonzo Lewis

(Address) 3133 E. Baltimore

15 FEB 7 1921

Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.-Every item of information should be given if possible, so that it may be properly classified. In order to state CAUSE OF DEATH in plain terms, so that it may be properly classified, the certificate is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 5 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921 to Feb 5 1921.

that I saw h-x alive on Jan 24 1921.

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Left leg

(Duration) Five yrs. .... mos. .... ds

Contributory (SECONDARY) Exhaustion

(Duration) .... yrs. .... mos. 20 ds.

(Signed) C. G. Trunk M. D.

Feb 6, 1921 (Address) 201 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oaklawn

DATE OF BURIAL: Feb 8 1921

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS: 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50617 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50617

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 First ave. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura C. Huber

(a) RESIDENCE. No. 3407 First ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benjamin Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Maggie Monkemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Benjamin Huber
(Address) 3407 First ave

15 Filed ....19.... Robert P. Harrison, Registrar

FEB 7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26th, 1921, to Feb 6th, 1921, that I last saw her alive on Feb 6th, 1921, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Good

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Circumstances

(Signed) W. H. Schwatka, M. D.

, 19 (Address) 734 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Feb. 8 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

mation called for on both sides of this certificate, so that a CAUSE OF DEATH in plain terms, so that a TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

40952
D.50618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50618

X 105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hans Larson.

(a) RESIDENCE. No. 12 West Fst, Spws, At ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charley James (Friend)

6 DATE OF BIRTH (month, day, and year): June 29, 1849.

7 AGE: 71 Years | 7 Months | 5 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipbuilder 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norway.

PARENTS

10 NAME OF FATHER: Hans Larson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway.

12 MAIDEN NAME OF MOTHER: Theodocia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norway.

14 Informant: J. H. Hospital records

(Address)

15 Filed FEB 7 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1921, to Feb. 3, 1921, that I last saw him alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 7 05 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis acute
Stomatitis acute
(Cause unknown at present

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. K. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health, FOR WM. F. WOODALL

ADDRESS FEB 7 1921

CAUSE OF DEATH TO BE ENTERED IN THIS SPACE. See instructions on back of certificate. TION is very important.

D. 50619 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50619

CERTIFICATE OF DEATH.

150

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2404 Bruce ST. 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Harris

(Residence in Baltimore: No. 2404 Bruce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	single

6-DATE OF BIRTH, ... Feb (Month) 4 (Day), 1921 (Year)

7-AGE, ...yrs. 7 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Henry Harris

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Kate Harris

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Harris

(Address) 2404 N Bruce St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk

N. B.—Every item of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Forensom, Ovarb Suppuration
Tuberculosis Peritonitis

(Duration) .....yrs. .....mos. 1/2 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Feb 5, 1921 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
FEB 7 1921
Commissioner Health,
Per Wm. F. WOODALL.
FEB 7 1921

10,50620 HEALTH DEPARTMENT—CITY OF BALTIMORE 10,50620

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 S. Charles St. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Petre Sedelo.

(Residence in Baltimore: No. 718 S. Charles St. St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. ..Do not know.., 1 ..
(Month) (Day) (Year)

7-AGE. ..22.. yrs. ..---.. mos. ..---.. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer in 040
(b) General nature of industry, business, or establishment in which employed (or employer). Chemical factory

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grebliauckas.

(Address) 425 S. Paca St.

15- FEB 7 1921 Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..February 5th. 1921.., 191 ...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autpsy & Inqry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) & inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Acute dilatation of the Heart
.....
..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Feb. 7...., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislovas	Feb. 8.., 1921
20-UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St.

DEATH CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50621 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50621

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1265 Sargent ST.: 21 WARD)

2-FULL NAME George H Howard

(a) RESIDENCE. No. 1265 Sargent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Howard

6 DATE OF BIRTH (month, day, and year): June 18/1874

7 AGE: Years 46 Months 7 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lather

(b) General nature of industry, business, or establishment in which employed (or employer): 05

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Boston Mass

PARENTS

10 NAME OF FATHER: John Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Mary O Mahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass

14 Informant (Address): Mary Howard 1265 Sargent St

15 Filed FEB 7 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to July 5, 1921, that I last saw h alive on July 5, 1921, and that death occurred, on the date stated above, at 6.25 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Davis M. D.

, 19 (Address) 1227 Columbus Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet DATE OF BURIAL: July 8 19 21

20 UNDERTAKER: Wm Cook & Son ADDRESS: Baltimore

CAUSE OF DEATH to be plainly written. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

10.50622

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.50622

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 E North Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Ragland

(Residence in Baltimore: No. 1104 E North Av St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April 7, 1853
(Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work R.R. Engineer 873
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Ford

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah E. Ragland

(Address) 1104 E. North Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

FEB 7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 7th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from FEB 6 1921 191, to FEB 7 1921 191,
that I saw him alive on FEB 7 1921 191,
and that death occurred, on the date stated above, at 7.30 A.m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 or 3 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

FEB 7, 1921 (Address) 925 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Feb. 9, 1921
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave

Important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50623 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50623

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1607 mc cullohST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Berry

(a) RESIDENCE. NO. 1607 mc Culloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dead

6 DATE OF BIRTH (month, day, and year) Unknown, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dover Balto Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Kate Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Caroline Potter (Address) 1607 Mc Culloch St

15 Filed Robert P. Harrison, Registrar

FEB 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1921, to Feb. 4, 1921, that I last saw h.. alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 12 N. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

1

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Old age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

7-4-1921 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Woodlawn Cem	Feb 8 1921
20 UNDERTAKER	ADDRESS 78
Edmund J Hendley	W Balto

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 lks.

D.50624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50624

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 320 Worsley St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie James Jenkins

(a) RESIDENCE. No. 320 Worsley St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	aa	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —Single—

6 DATE OF BIRTH (month, day, and year) Aug 26 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) 320 Worsley St.
(State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Bennie Jenkins

11 BIRTHPLACE OF FATHER (city or town) Chesterfield
(State or country) Co. Va

12 MAIDEN NAME OF MOTHER Mary Hayward

13 BIRTHPLACE OF MOTHER (city or town) Dynahburg
(State or country) Virginia

14 Informant Mother
(Address) 320 Worsley St

15 Filed FEB 8 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2nd, 1921, to Feby 6th, 1921, that I last saw him alive on Feb 6th, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) 4 yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Gastro enteritis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edd L Dulls, M. D.

19 (Address) 416 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cmty	2/8 1921
20 UNDERTAKER Mrs Robt a Ellwood	ADDRESS 1725 Carey

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50625 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50625

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ben. Carroll

(a) RESIDENCE. No. 1442 Eastern Ave. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown 30 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER John Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Martha McLean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed Robert P. Harrison, Registrar

8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1921, to Feb. 6, 1921, that I last saw h.. im alive on Feb. 6, 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) L. S. Fahndrich. M. D.

2-7-21. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedarcy Cemetery	2/9, 1921
20 UNDERTAKER Mrs Robt a Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—3000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50626

D.50626

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Elsinore ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Eichman

(Residence in Baltimore: No. 2712 Elsinore ave St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 3, 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. 2 mos. 4 da.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel Eichman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary C Schneider

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Eichman

(Address) 2712 Elsinore ave

15-

Filed FEB 8 1921, by Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 7, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1921, to Feb 7th 1921, that I saw him alive on Feb 7th 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (Duration) 2 hrs. mos. ds.

(Signed) Dawson T Harby M. D.

Feb 7; 1921. (Address) Dawson T Harby

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feb 9, 1921

20-UNDERTAKER H Prudent Johns

ADDRESS North Ave

important. See instructions on back of certificate

Spec.—8-24-14—M. & T.—2000 Bks.

20.50627

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50627

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 215 Singer Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara W. Strohmeyer

(Residence in Baltimore: No. 215 Singer Ave / St.: 63 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1857 (Year)

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harry White

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Blackiston

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Strohmeyer

(Address) 215 Singer Ave

15-

Filed FEB 8 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 2 1921, to Feb. 6 1921, that I saw h*er* alive on Feb. 5 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Dementia

(Duration) 1½ yrs. ..... mos. ..... ds.

(Signed) M Bowman Lord M. D.

Feb. 7, 1921. (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Feb. 8, 1921

20-UNDERTAKER Wm J Fleckenstein & Sons

ADDRESS No 11 E Fa

Sec. 8. See instructions on back of certificate. Answers to questions must be full and complete. Use ditto marks only when they will be understood. Write plainly and use ink. Do not use abbreviations or initials except in signatures. Be sure to answer every question. Do not leave any blanks. If any question is not applicable, write "None" or "Unknown," as the case may be. Items 1 to 15 must be answered before a burial permit will be issued. Items 16 to 20 must be answered before a certificate will be registered. Sec. 9. Any person who shall refuse or neglect to comply with the requirements of this section shall be guilty of a misdemeanor and shall be punished by a fine of not more than $100.00.

Spec.—8-24-14—M. & T.—2000 Bks.

20.50628 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 N Chester St.; 8 Ward)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Berger

(Residence in Baltimore: No. 1810 N Chester St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 17, 1856
(Month) (Day) (Year)

7-AGE, 64 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home 37
(b) General nature of industry, business, or establishment in which employed (or employer) Work

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Fred Stenmel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kath Berger Sr

(Address) 1810 N Chester

15- FEB 8 1921

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 6 - 21, to Feby 6 - 21,
191 191
that I saw h alive on 191,
and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Katherine A. Berger M. D.

8, 21 (Address) 1810 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dale Cemetery — DATE OF BURIAL, Feby 9, 1921.

20-UNDERTAKER Robt Turner Son — ADDRESS 1442 N Bway

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,50629 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50629

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Scott

(a) RESIDENCE. No. 1931 Bank st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Keenan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M. T. H.

15 Filed FEB 8 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1920, to Feb. 6, 1921, that I last saw h alive on Feb. 6, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 24 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Ls. S. Fahndrich. M. D.

2-7-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Cemetery	Feby 8 1921
20 UNDERTAKER	ADDRESS
Robt J Turner Inc	1424 N Bway

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate. TION is very important.

D.50630 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50630

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1016 Leadenhall St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Sedgwick. (C)

(Residence in Baltimore: No. 1016 Leadenhall St, St.; yrs. 7 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single.

6-DATE OF BIRTH, June 20th. 1920., 1
(Month) (Day) (Year)

7-AGE, ---yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Horrace Sedgwick (C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Ida Matthews. (C)

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Sedgwick. (C) mother.

(Address) 1016 Leadenhall St.

15- FEB 8 1921 Filed ....., 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 7th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Eranchs-pneumonia.

Unknown. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. M. Feinhardt M. D.
(Coroner.)

Feb. 7th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn ct DATE OF BURIAL, Feb 8, 1921

20-UNDERTAKER C. L. Brown & Son ADDRESS 108 W. Mulberry St

D. 50631 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50631

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 14 W. York St. ST.: 27 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Bolden.(C)

(Residence in Baltimore: No. 14 W. York St. St.: 41 yrs., 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, March 14th. 1879, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 10 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 0
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John W. Morsell.(C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Priscilla Dawkins(C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Morsell.(C) brother.

(Address) 128 W. Hughes St.

15- Robert P. Harrison,
Filed ..... 191 Burial Permit Clerk.
Registrar.

CAUSE OF DEATH in plain terms, so that it may be understood. All items important. See instructions on back of certificate.

FEB 8 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 6th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) H. W. Emhardt M. D.
(Coroner.)

Feb. 7th. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn ct	Feb 8, 1921
20-UNDERTAKER	ADDRESS
L. R. Brown & Son	108 W. Mulberry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50632 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50632

CERTIFICATE OF DEATH. 91-089

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 w. Hill ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Boone

(a) RESIDENCE. NO. 205 W. Hill ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 26th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Howard Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Eleanor Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Howard Boone

(Address) 205 w. Hill st

15 Filed . 19 Robert F. Harrison, Registrar

FEB 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6th 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 3rd, 1921, to Feb 6, 1921, that I last saw him alive on Feb 5th, 1921, and that death occurred, on the date stated above, at 12-15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

following (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D H Lawree, M. D.

2/9. 1921 (Address) 140 N. Hill st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn.	Feb. 8 1921
20 UNDERTAKER D. L. Brown & Sons	ADDRESS 108 W. Montgo

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50633 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 57

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Cilinski

(a) RESIDENCE. NO. 121 Church st, Curtis Bay. WARD 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Cilinski

6 DATE OF BIRTH (month, day, and year) 1891(?)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Cilinski (Address) 121 Church st

15 Filed FEB 8 1921 Registrar Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to Feb 7, 1921, that I last saw h[illegible] alive on Feb 7, 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B Blackstone, M. D.

2/7/1921 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co	Feb 8 1921
20 UNDERTAKER Grant Crook & Son	ADDRESS 1406 Gorsuch Ave

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50634 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Penna Road, ST.: 4 X 45 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. John Mueller

(a) RESIDENCE. NO. Marietta, Penna. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Anna M.

6 DATE OF BIRTH (month, day, and year) Sept. 12, 68

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna Lancaster

PARENTS

10 NAME OF FATHER Wm. Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath. Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Mueller

(Address) Marietta Pa

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/21 1921, to 2/6 1921, that I last saw h— alive on 2/6 1921, and that death occurred, on the date stated above, at 6 X 2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Protestant

What test confirmed diagnosis?

(Signed) Wm. A. Fahl, M. D.

2/6, 1921 (Address) Penna Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marietta Pa	2/8/21 19
20 UNDERTAKER Geo. & Jules Sutton	ADDRESS Marietta

CAUSE OF DEATH to be given in plain terms. See instructions on back of certificates. TION is very important.

20.50635 HEALTH DEPARTMENT--CITY OF BALTIMORE 20.50635

1-PLACE OF DEATH

CERTIFICATE OF DEATH

92

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1507 Henry St. St. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G. Pennell

(Residence in Baltimore: No. 1507 Henry St. St.: 26 yrs. ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male.	White.	Single.

6-DATE OF BIRTH: December 27th. 1886., 1 (Month) (Day) (Year)

7-AGE: 34 yrs. 1 mos. 11 ds. If LESS than 1 day, ... hrs. or ---- min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk B. & O. R. R. Co.
(b) General nature of industry, business, or establishment in which employed (or employer): 609

9-BIRTHPLACE (State or country): West Virginia.

PARENTS

10-NAME OF FATHER: Charles H. Pennell.

11-BIRTHPLACE OF FATHER (State or country): Pennsylvania.

12-MAIDEN NAME OF MOTHER: Margaret Kearns.

13-BIRTHPLACE OF MOTHER (State or country): West Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles H. Pennell. (father)

(Address) 1507 Henry St.

15. Filed FEB 8 1921, 19.. Robert P. Harrison, Burial Permit Clerk. REGISTRAR

N.B.-Every item of information must be given so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February 5th. 1921., 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 5th., 1921, to February 6th 1921, that I saw him alive on February 6th., 1921., and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. 8 ds

Contributory (SECONDARY) Apnoea.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto H. Reinhardt M. D.

Feb 7th., 1921. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: 2/8 1921

20-UNDERTAKER: J. Fran McCully ADDRESS: 130 E. Fred

Spec.—5-19-13—M. & T.—500 Bks.

D. 50636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 E North Ave ST.; 9 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav Kleinrodt

(Residence in Baltimore: No. 830 E North Ave St.; 64 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Intarum (Month) — (Day), 1847 (Year)

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk in Grocery
(b) General nature of industry, business, or establishment in which employed (or employer): Store

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. S. Ludwig

(Address) 830 E. North Ave

15-

Filed FEB 8 1921, 191

Robert P. Harrison, Burial Permit Clerk, Registrar.

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1920, to Feb 6 1921, that I saw h[illegible] alive on Feb 5 1921, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary disease of Heart

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. J. Ludwig M. D.

Feb 7, 1921. (Address) 830 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feby. 8, 1921

20-UNDERTAKER J O Mitchell — ADDRESS 1201 W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50637 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50637

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Mc Elderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Emory

(a) RESIDENCE. No. 2024 McElderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Edw. Emory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Fussell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edw. Emory
(Address) 2024 McElderry

15 Filed Robert P. Harrison, Registrar

FEB 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1921, to Feb 6, 1921, that I last saw h.. alive on Feb 6, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

a. b.

Prematurity

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Francis J. Ayd, M. D.

, 19 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross, Cem	Feb 7th 1921
20 UNDERTAKER	ADDRESS
Geo M. Frist & Son	811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50638 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50638

CERTIFICATE OF DEATH. 19-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 E Chase St.: 11 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Whitney

(a) RESIDENCE. No. 202 E Chase St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Caroline Clark Whitney

6 DATE OF BIRTH (month, day, and year) 1857-5-14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamship do

(b) General nature of Industry, business, or establishment in which employed (or employer) Operator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Joseph C. Whitney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Anna Weston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Caroline C. Whitney (Address) 202 E. Chase

15 Filed FEB 8 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1920, to Feb. 7th, 1921, that I last saw him alive on Feb. 7th, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

Paralytic Acute Bilateral

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis Cerebri of Lisa

(duration) 10 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) J. A. Chatard, M. D.

Feb 8th 1921 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	2-8 1921
20 UNDERTAKER Newman & Jenkins Undertaking Co	ADDRESS McCulloh & Richard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Do not report symptoms, but the disease causing death. Do not report conditions resulting from disease, but the disease itself. Do not report modes of dying, such as heart failure, asphyxia, exhaustion, etc., but the disease causing the condition. Do not report merely "accident," "homicide," "suicide," "drowning," but the nature of the accident, homicide, suicide, or drowning. In deaths from violence, state the means of injury, whether accidental, suicidal, or homicidal. In deaths of women, always state whether single, married, widowed, or divorced. In deaths of children, always state whether legitimate or illegitimate. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50639 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 26 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Meekins

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 5, 19 21

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1921, to February 5, 1921 that I last saw her alive on February 4, 1921 and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) P. Hermann M. D

2/5/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb. 8, 1921
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

Spec.—6-9-19—H. P. Co.— 1000 Bks.

20.50640

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50640

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Johns Hopkins hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne M. Canity

(a) RESIDENCE. NO. 621 S Potomac ST. Baltimore Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. Life ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. pd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Canity

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Clothilda Lense

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant J. H. Hospital records
(Address)

Filed FEB 8 1921. 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-21 19

17 I HEREBY CERTIFY, That I attended deceased from May 2 - 1921, to Feb - 17 - 1921,

that I last saw her alive on Feb. 7 1921,

and that death occurred, on the date stated above, at 6 to P m.

The CAUSE OF DEATH* was as follows:

Erythroblastosis
Bronchopneumonia

(duration) — yrs. 9 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home Hospital

Did an operation precede death? No Date of ...

Was there an autopsy? Yes.

What test confirmed diagnosis? None.

(Signed) W. Davison, M. D.

2-8, 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Febr 8 19
20 UNDERTAKER	ADDRESS
Louis Heemann	325 Broadway

CAUSE OF DEATH. See instructions on back of this CERTIFICATE. ATTENTION is very important.

STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 50641

50641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Bond ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Young

(a) RESIDENCE. NO. 820 N. Bond St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 8 mos. ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of #

6 DATE OF BIRTH (month, day, and year) May 13 1920

7 AGE: Years — Months 8 — Days 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None any

(b) General nature of industry, business, or establishment in which employed (or employer) ~~~

(c) Name of employer Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Moses Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Cambridge

12 MAIDEN NAME OF MOTHER Lillion Moloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Moses Young (Address) 820 N Bond St

15 Filed FEB 8 1921, 19 Robert J. [illegible] Registrar

Burial Permit Clerk

CAUSE OF DEATH. ATTENDING PHYSICIAN is very important. See instructions on back of this blank.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 7, 1921, that I last saw her alive on Feb 7, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

2/7, 1921 (Address) J. E. Thomas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: Feb 8 1921

20 UNDERTAKER: John W Henderson

ADDRESS 1502 E Mount

Spec. 6-9-19—H. P. Co.—1000 Eks.

D. 50642

D. Number 50642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Mitchell (Balto.)

(a) RESIDENCE. No. 1426 East Monument St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Waddell Mitchell (Father).

6 DATE OF BIRTH (month, day, and year) Jan 22-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Waddell Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ethel Minor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Johns Hopkins Hospital (Address) Records

15 Filed ..... 19.. Robert P. Harrison Registrar

FEB 8 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb 6, 1921, that I last saw h.. alive on Feb 5, 1921, and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W R Davison, M. D.

, 19 (Address) 1414 Ballard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Feb 8 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH must be given in full. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,50643 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 50643

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 W Lexington St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. C. Mertz

(a) RESIDENCE. NO. 731 W Lexington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Mertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Ella Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mr C Charles Mertz
(Address) 731 W Lexington St

15 Filed Feb 9 1921 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb. 7, 1921, that I last saw him alive on Feb. 7, 1921, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry H. Weinberg M. D.

Feb. 9 1921 (Address) 724 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Feb 9 1921

20 UNDERTAKER John J. Lowry & Son ADDRESS 900 Hollins St

CAUSE OF DEATH to be filled in by physician. See instructions on back of certificate. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50644 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50644

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2406 E. Balto ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa E. Franz

(a) RESIDENCE. No. 2406 E. Balto ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 18-88

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Julius Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Bastl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Julius Franz 2406 E. Balto

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

CAUSE OF DEATH. See instructions on other side. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1921, to Feb 5, 1921, that I last saw h.er alive on Feb. 4, 1921, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Pate. PK. av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feby 8 1921
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Aliceanna

Spec.—6-9-13—H. P. Co.—1000 Rec.

20.50645

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 20.50645

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 616 Wayne ST. 27 WARD)

2-FULL NAME Elizabeth Williams

(a) RESIDENCE. NO. 616 Wayne Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of July 27 - 1854

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James a Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rebecca Kinnon (Address) 616 Wayne Ave

15 Filed ..... 19.. Robert P. Harrison Registrar

FEB 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to Feb 6, 1921, that I last saw h.. alive on Feb 5, 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) — yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) As Above (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 616 Wayne Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. N. Hinson M. D.

Feb 8, 1921 (Address) 712 S. Bond St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Feb 8 1921

20 UNDERTAKER S. L. Brown & Son — ADDRESS 107 N. [illegible]

"CAUSE OF DEATH" must be filled in plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50646

CERTIFICATE OF DEATH.

X 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter A. Bowen

(a) RESIDENCE. NO. # 125 St James St. ST., WARD. Calvert Co. Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed,) or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Annie E. Bowen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Abt	117 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Fletcher Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Elizabeth Buckeley Fort St. Org. Mass

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 7 1921, that I last saw him alive on Feb 7 1921, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Hypertension

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) Uncertain yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Geyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Drake Wharf - Calvert Co.

DATE OF BURIAL: Feb 10 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E. Hatt Ave.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50647 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50647

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1035 Wilcox Av. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Esender. Esender.

(a) RESIDENCE. No. 1035 Wilcox. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Esender

6 DATE OF BIRTH (month, day, and year) (Don't Know) 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Mary. O'Hara

(Address) 814 Willow St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1921

17 I HEREBY CERTIFY, That I attended deceased from February-6, 1921, to February-7, 1921.

that I last saw him alive on February 6, 1921,

and that death occurred, on the date stated above, at 6-20 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs - Cardiac Dilatation

Uremic Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination.

(Signed) William F. Schwartz. M. D.

2/7, 1921 (Address) 1200 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross.	Feb 9 1921 19

20 UNDERTAKER Woolcock ADDRESS 504 E. Monument

CAUSE OF DEATH ... TION is very important. See instructions on back

...NITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to Exposure

Spec.—8-24-14—M. & T.—2000 Bks.

20.50648 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50648

CERTIFICATE OF DEATH.

10-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 Gold St ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Keys

(Residence in Baltimore: No. 705 Gold St St. 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 7th (Month) (Day), 1871 (Year)

7-AGE, 49 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Colored
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ben Moore

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Keys

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Keys

(Address) 705 Gold St

15- Robert P. Harrison,

Filed ....., 191..... Burial Permit Clerk. Registrar.

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 5th (Month) (Day), 1931 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 18th 1931, to Feb 5th 1931, that I saw h— alive on Feb 5th 1931, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) La Grippe

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) J Wellington Davis M. D.

Feb 6th, 1931 (Address) 1401 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Feb 7th, 1931

20-UNDERTAKER Harmon & Wright — ADDRESS 1534 McCulloh

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50649 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50649

CERTIFICATE OF DEATH. 92-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F Chenoweth Jr

(a) RESIDENCE. NO. 114 Poplar ~ Curtis Bay St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony (Mary)

6 DATE OF BIRTH (month, day, and year) Oct - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Curtis Bay Copper & Iron Works Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Geo. F Chenowith

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Maggie Hogan

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs. Anthony (Address) 114 Poplar Ave

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 6 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1921, to 2-6, 1921, that I last saw h alive on 2-6, 1921, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Tuy Bacterial Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Work

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) F. W. Hooper, M. D.

19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wood Lawn Cemetery	Feb 8th 1921
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~15477~~ 20.50650

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50650

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Herrmann

(a) RESIDENCE. No. 1953 Patterson Park Ave, Balto ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) ~~WIFE~~ of Mrs. Carrie Heffernan (Daughter)

6 DATE OF BIRTH (month, day, and year) April - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph ? Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Clerk

15 Filed AUG 8 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1921, to Feb. 7, 1921, that I last saw her alive on Feb. 7, 1921, and that death occurred, on the date stated above, at 10½0 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Thyroid

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Cancer of Brain (Met. from)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1918

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. R. Mason M. D.

2-7. 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb 10 1921
20 UNDERTAKER	ADDRESS
Henry Houck & Son	1301 E Eager

CAUSE OF DEATH must be stated on back of certificate. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50651

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 314 E. 20th ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Waud.

(a) RESIDENCE. NO. 3147 E. 20th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Regina Waud.

6 DATE OF BIRTH (month, day, and year) Don't Know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder Jobber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co- Md.

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant (Address) Mary Regina Waud 3147 E 20th St

15 Filed FEB 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7- 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1921, to Feb 7, 1921.

that I last saw h.. alive on Feb 7, 1921.

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy - Hemiplegia (duration) yrs. mos. 2½ hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Tovey, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Feb. 9 1921

20 UNDERTAKER William Cook — ADDRESS 502 E. North

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

(Southoron)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50652 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50652

CERTIFICATE OF DEATH. X108

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Doreta Southoron

(a) RESIDENCE. NO. Mechanicsville ST. 2nd WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co Md

PARENTS

10 NAME OF FATHER Leon Southoron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) George Southoron Mechanicsville Md

15 Filed ....., 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

AUG 8 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1921 to Feb. 7 1921

that I last saw h[illegible] alive on Feb. 7 1921

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Sore Throat (Vincents stapholococcic) over

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ulcerative Endocarditis

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? Her residence

Did an operation precede death? yes Date of Jan 8. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Dr. M. Stitt M. D.

(Address) 1430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlotte Hall Md	Feby 8. 1921
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	W. North Ave

CAUSE OF DEATH: See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Appendicitis - Peritonitis

Spec.—6-9-19—H. P. Co.—1000 Pks.

D. 50653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50653

10-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2536 Boyd ST.; 7th WARD)

2-FULL NAME William C Eichen

(a) RESIDENCE. NO. 2536 Boyd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Eichen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Anna Bernatka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Christian Eichen

(Address) 2536 Boyd St

15 Filed FEB 8 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to Feb 7, 1921, that I last saw him alive on Feb 7, 1921, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R L Ruyell M. D.

19 (Address) Wentworth 4th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb: 9 1921
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk: Ave:

CAUSE OF DEATH ... TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

10.50654 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.50654

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH Hebrew Aged Home REGISTERED NO.....

CITY OF BALTIMORE: (No. 105 Aisquith ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Cohen

(a) RESIDENCE. NO. 101 S. Spring ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Jacob Cohen

6 DATE OF BIRTH (month, day, and year) — 1821

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	100			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Baltimore St.

15 Filed FEB 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb. 8, 1921, that I last saw her alive on Feb. 1, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) M. J. Bayle, M. D.

2/10, 1921 (Address) 2101 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd.	Feb 8 1921

20 UNDERTAKER Jack Lewis, 1411 ADDRESS E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50655 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50655

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs ~~Dora~~ Theodosia Ramsey

(a) RESIDENCE. No. 229 N. Calhoun St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 2/17-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md City

PARENTS

10 NAME OF FATHER Sylvester Renner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Adeltha Rhoads

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John P. Renner

(Address) 229 N. Calhoun St

15 Filed FEB 8 1921 Robert F. Harris Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec- 8, 1920, to Feb- 7, 1921, that I last saw her alive on Feb- 7th, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of 1/24/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Woodruff, M. D.

2/7, 1921 (Address) Franklin Square Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 9th 1921
20 UNDERTAKER	ADDRESS
George Smith	1000 Fayette St

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.50656

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.50656

CERTIFICATE OF DEATH.

± 92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kelly

(a) RESIDENCE. NO. St. Charles College ST., Catonsville WARD Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. ? 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newton Mass
(State or country)

PARENTS

10 NAME OF FATHER Michael J Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Davock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant John Kelly
(Address) St Charles College Catonsville Md

15 Filed Robert P. Harlow Registrar

B8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 1921, to 2-8, 1921, that I last saw h[illegible] alive on 2-8, 1921, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia 5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Char Colleg[illegible]

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) C. W. Crain, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newton Mass

DATE OF BURIAL 2-8 1921

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

TION IS VERY important.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50657

CERTIFICATE OF DEATH.

92-010

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 Hilton ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agusta Gronicka

(Residence in Baltimore: No. 2514 Hilton ave St.; 48 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 15th (Month) (Day), 1882 (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Lichtenhage

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore Gronicka

(Address) 2514 Hilton Av

15- Filed FEB 8 1921, 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 4, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 1 1921, to February 4 1921, that I saw h[illegible] alive on February 3 1921, and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Influenza & Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert C. Hebb M. D.

Feb. 7, 1921 (Address) 2151 Hilton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery DATE OF BURIAL, Feb 8th, 1921

20-UNDERTAKER F B Kappauf ADDRESS 2236 Eutaw Pl

Cross out words not important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

050658 HEALTH DEPARTMENT—CITY OF BALTIMORE 050658

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Frederick Av St., 20 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Sauerbrei.

(Residence in Baltimore: No. 2313 Frederick ave St.; 78 yrs., 9 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widowed

6-DATE OF BIRTH, May (Month) 14 (Day), 1842 (Year)

7-AGE,	If LESS than 1 day,
78 yrs. 9 mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frederick Fauth

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Sauerbrei

(Address) 2313 Frederick Av

15- FEB 8 - 1921 ROBERT E KRAUTER Registrar.

Filed ..... 191.... Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 7 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 4 1921, to February 7 1921, that I saw h[illegible] alive on February 5 1921, and that death occurred, on the date stated above, at 8 1/2 m.

The CAUSE OF DEATH* was as follows:

1. Endocarditis
Interstitial nephritis
(Duration) 4 days.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Robert E Krauter M. D.

Feb 7, 1921 (Address) 2151 Baltimore

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Feb 11 1921
20-UNDERTAKER	ADDRESS
H B Kuhlmann	223 Fred'k Av

CAUSE OF DEATH must be filled in by the attending physician. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050659

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 050659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 S Linwood ave ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Andrew Markiewicz

(a) RESIDENCE. No. 1103 S Linwood ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John J Markiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Agnes Kuginski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Stephen J Kraskowski

(Address) 1004 S Linwood

15 Filed FEB 8 1921

EVERETT B KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1921, to Feb 8, 1921, that I last saw h alive on Feb 8, 1921, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth
five months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. C. Heaver, M. D.

(Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Feb 8 1921

20 UNDERTAKER: Stephen J Kraskowski — ADDRESS: 1004 S Linwood

CAUSE OF DEATH to plainly written or typewritten. See instructions on back of certificate. TION is very important.

Camm Ashley

D50660 HEALTH DEPARTMENT—CITY OF BALTIMORE D50660

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital St.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Camm Ashley

(Residence in Baltimore: No. Magnolia ave English Consul St.: (yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH, Nov. (Month) ....., 1 (Day) ..... (Year)

7-AGE, 85 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ship Captain

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Ashley

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Ashley

(Address) Mill Chester, Va.

15-

Filed FEB 8 1921, 191..... ROBERT B KRAUTER Chief Bureau of Vital Statistics Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture both Legs R. Shoulder, Internal Injuries, Cause accident

(Duration) ..... yrs. ..... mos. 8 hrs.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Houston M. D. (Coroner.)

Feb 7, 1921 (Address) 200 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. 8 hrs. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Magnolia Ave

Former or usual residence Magnolia Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Feb. 10, 1921
20-UNDERTAKER Joseph P. Cook	ADDRESS 1005 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050661

HEALTH DEPARTMENT—CITY OF BALTIMORE

050661

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2632 Hafer St. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Shipley

(a) RESIDENCE. No. 2632 Hafer St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maggie Shipley

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Shipley

11 BIRTHPLACE OF FATHER (city or town) Balto., Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Ann Bell

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant John A. Ricks
(Address) 916 W. 37th St.

15 FEB 8 1921 ROBERT B. FLASTER Registrar
Burial Permit Clerk

CAUSE OF DEATH to plainly ... See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Febr 7, 1921, that I last saw ~~him~~ alive on February 6, 1921, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis.
Aortic Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary Valves (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Hematuria

(Signed) Robert E. Pratt, M. D.

2/7, 1921 (Address) 2651 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridge Cemetery (Halethal)	Feb. 9 1921
20 UNDERTAKER Joseph B. Fox,	ADDRESS 1003 N. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050662 HEALTH DEPARTMENT—CITY OF BALTIMORE 050662

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Josph's Hospital

CITY OF BALTIMORE: (No. ..... ST.: 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Mrs) Margaret Somerville

(a) RESIDENCE. NO. 3711 Railroad Ave. ST., WARD. Woodberry

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER John Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Asked Mother 2-7-1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Asked Mother

11 Informant Mrs Somerville

(Address) 123½ Hanover

12 Filed FEB 8 - 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1921, to Feb. 7, 1921, that I last saw her alive on Feb. 7, 1921, and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? Yes Date of Jan 24. '21

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture & urine.

(Signed) F. C. Mauser, M. D.

2-7-1921 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Druid Ridge Feb 9 21

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCALITY must be given. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

b 50663 HEALTH DEPARTMENT—CITY OF BALTIMORE b 50663

CERTIFICATE OF DEATH. 115

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2933 Clifton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Rudolph.

(a) RESIDENCE. No. 2933 Clifton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Anna Rudolph

6 DATE OF BIRTH (month, day, and year) Dec 14-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gold Gilder

(b) General nature of industry, business, or establishment in which employed (or employer) Gilding

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berlin Md

PARENTS

10 NAME OF FATHER Vitus Rudolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Rudolph
(Address) 2933 Clifton Ave

15 Filed FEB 8TH 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1920, to Feb. 7, 1921, that I last saw him alive on Feb. 7, 1921, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Lung (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Roentgen Ray examination

H. K. Culmer M.D.
(Signed)

Feb 7, 1921 (Address) 2757 Wilmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Feby 10 1921
20 UNDERTAKER Robt J. Turner	ADDRESS 1422 Bolton

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0050664 HEALTH DEPARTMENT—CITY OF BALTIMORE 0050664

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Marshall St. ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bentz

(a) RESIDENCE. NO. 1506 Marshall St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Elmer C. Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Phelma Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant Emma Bell (Address) 1506 Marshall St

15 Filed ..... 19 ROBERT E KRAUTER Registrar

FEB 8 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1921, to Feb 7, 1921, that I last saw h... alive on Feb 7, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/8, 1921 (Address) 1 E Randall

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb. 8 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

Haenig

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050665

1050665

42

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Hanover St.: 23 WARD)

2-FULL NAME Cora Haenig

(a) RESIDENCE. No. 1223 Hanover St., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Juhsn yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry D. Haenig

6 DATE OF BIRTH (month, day, and year) April 16 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Md. Ave Maden Car Co.

9 BIRTHPLACE (city or town) (State or country) Henry Smith

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Hauk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Henry D. Haenig (Address) 1223 Hanover St.

15 Filed FEB 8 1921 ROBERT J. REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to Feb. 4, 1921.

that I last saw her alive on Feb. 4, 1921.

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Rectum

Acute (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Nov. 14-20

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. Eckel Bracken, M. D.

Feb. 6, 1921 (Address) 1412 Lovett Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co.	Feb. 9 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Eager St.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50666

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N. Carey ST.; 21 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank V. Jaschik

(a) RESIDENCE. No. 400 W. Ostend ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alfred F. Jaschik.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mildred M. Lamb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mildred M. Jaschik.
(Address) 400 W. Ostend ST.

15 Filed FEB 8 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1920, to Feby 7, 1921, that I last saw him alive on Feby 6, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Unresolved Pneumonia

(duration) about yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Purulent Pericarditis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. H. V. Cliff M. D.

Feby 7, 1921 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Feb 9 1921

20 UNDERTAKER Margaret M. Flynn

ADDRESS 1422 Light St.

TION is very important. See instructions on back of CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105067 105067

92-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N. Vincient St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME King Bradley

(a) RESIDENCE. NO. 115 N. Vincient St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Bradlet

6 DATE OF BIRTH (month, day, and year) 7/17/ 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labored 040

(b) General nature of industry, business, or establishment in which employed (or employer) Loading waggons.

(c) Name of employer American Ice Co.

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co. Va.

PARENTS

10 NAME OF FATHER Thomas Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westmoreland Co. Va.

12 MAIDEN NAME OF MOTHER Anna Stwert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westmoreland Co. Va.

14 Informant Hattie Bradley
(Address) 115 N. Vincient St.

15 Filed FEB 8 1921 ROBERT P. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/'21 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26th, 19 21, to Feb. 6 1921, 19, that I last saw him alive on Feb. 5th. 1921, 19, and that death occurred, on the date stated above, at 8:35 a m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Rt.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam.

(Signed) Walter Jackson, M. D.

, 19 (Address) 1615 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 9th 1921
20 UNDERTAKER	ADDRESS
A. Jones	207 S Stricker st

CAUSE OF DEATH TO BE FILLED IN BY PHYSICIAN ONLY. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50668

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50668

CERTIFICATE OF DEATH.

9

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Vine ST. 19 WARD)

2-FULL NAME Beatrice Peter

(a) RESIDENCE. No. 1514 Vine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

FEB 8 1921 ROBERT J. KRAUTH

15 Filed ..., 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 7, 1921, to Feby 7, 1921, that I last saw her alive on Feby 7, 1921, and that death occurred, on the date stated above, at 2 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) yrs. mos. Durks ds.

CONTRIBUTORY (Secondary) Clinical Nasal Diphtheria?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Cliff, M. D.

Feby 8 1921 (Address) Robt Garrett Hosp Dispensary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	2/8 1921
20 UNDERTAKER Commissioner Health.	ADDRESS

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050669

1050669

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pierce

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Pierce

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hickleson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant
(Address)

15 Filed FEB 8 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from September 24 1914, to February 6, 1921, that I last saw him alive on February 5, 1921, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) B. Herman, M. D.

2/6/ 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 8 1921

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1456 89 2050670 +92 2050670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

2-FULL NAME Perry Leach

(a) RESIDENCE. No. 817 North Side, Spus St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	colored.	single.

5a If married, widowed, or divorced. ~~HUSBAND of~~ ~~(or) WIFE of~~ Mary Miller (sister).

6 DATE OF BIRTH (month, day, and year) Mar. 4, - ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Sam: Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed FEB 8 - 1921 ROBERT A. CARTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1921, to Feb. 3, 1921, that I last saw him alive on Feb. 3, 1921, and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. R. Mason M. D.

2-4, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 8 1921

20 UNDERTAKER Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

050671

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

2-FULL NAME Baby Grimes

(a) RESIDENCE. No. 715 Sterling St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Blanch- ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant J. H. Hospital Records

(Address)

15 Filed FEB 8 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 - , 1921, to Feb 3 , 1921, that I last saw h.. alive on Feb 3 , 1921, and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W C Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 8 1921

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per Wm. E. WOODALL

CAUSE OF DEATH must be properly certified. See instructions on back of certificate. TION is very important.

D50672 Wm A. Lavelle D50672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 168

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. Mercy Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Lavelle

(Residence in Baltimore: No. 1032 Hillen St.; abt 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Don't Know (Month) (Day), 1868 (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 0?

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Jennings

(Address) 822 Ensor

15- Filed FEB 8 1921 19.. ROBERT B KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism — 2 Days Intoxication

Coma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmon Edema

(Duration) yrs. mos. ds.

(Signed) H. J. Kelly M. D. (Coroner.)

Feb 8, 1921 (Address) 1639 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Canton Md.

19-PLACE OF BURIAL OR REMOVAL, Druid Hill — DATE OF BURIAL, Feb 8, 1921

20-UNDERTAKER, Robt J Jones — ADDRESS 1442 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

D50673 HEALTH DEPARTMENT—CITY OF BALTIMORE D50673

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2600 E. Baltic WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Grass.

(Residence in Baltimore: No. 523 N. Bradford. St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Baby

6-DATE OF BIRTH, Jan 8th (Month) (Day), 1920 (Year)

7-AGE, 1 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Gross.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Frances Potter

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gross

(Address) 523 N. Bradford.

15- Filed FEB 8 1921 ROBERT J. CRAUTER Registrar of Vital Statistics

N.B. CAUSE OF DEATH in plain terms, so that it may be properly coded. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

18-CAUSE OF DEATH* was as follows: Poisson by taking tablets Corrosive Sublimate Suicidal

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) H. Adler (Coroner) M. D.

2-7, 1921 (Address) 4 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Feb 9, 1921

20-UNDERTAKER Thos. E. Miller ADDRESS 2334 Jefferson St

Spec. 6-9-19 H. P. Co. 1000 Bks.

950674

HEALTH DEPARTMENT—CITY OF BALTIMORE

950674

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Nolte

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Lemal Stansbury

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER Susan Green

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed FEB 8 1921 ROBERT S. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1920, to February 6, 1921, that I last saw her alive on February 6, 1921, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) B. H. Newman, M. D.

2/7/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 9 1921
20 UNDERTAKER	ADDRESS
Johnson & Sanders	946 Aisquith

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

50675 HEALTH DEPARTMENT—CITY OF BALTIMORE 50675

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2729 Winchester ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Curley

(a) RESIDENCE. No. 2729 Winchester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Curley

6 DATE OF BIRTH (month, day, and year) Oct. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hoban

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Cecelia Curley

(Address) 2729 Winchester St

15 Filed FEB 8 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1921, to Feb 4, 1921, that I last saw her alive on Feb 4, 1921, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY, Myocarditis from
(secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) John L. Krakauer, M. D.

Feb 7 1921 (Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Feb 9 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations or initials. Do not state mode of dying, such as heart failure, asphyxia, etc., but what disease caused such failure, asphyxia, etc. Indefinite and unsatisfactory terms will be returned for correction. Consult the list of diseases in the Physician's Handbook. Name the disease causing death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. Operations, conditions, and contributory causes should be stated in addition to the primary cause. Write plainly with pen and ink. Use no lead pencil. Sign and return this certificate to the Registrar who issued it. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

150676

HEALTH DEPARTMENT—CITY OF BALTIMORE

150676

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3413 E. Pratt ST. 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Osidor Bucher.

(a) RESIDENCE. NO. 3413 E. Pratt ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa M. Bucher.

6 DATE OF BIRTH (month, day, and year) Jan. 29-1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Jos. Bucher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Theresa M. Bucher.
(Address) 3413 E. Pratt St.

15 Filed FEB 8. 1921 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan-2- 1920, to Feb 6- 1921, that I last saw h— alive on Feb 5- 1921, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Dis - Chronic -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Anasarca —

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Frank C Bucher — , M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 9 1921
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S Broadway

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50677

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1112 Thompson ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Maddox

(a) RESIDENCE. No. 1112 Thompson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years	9 Months	— Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Rufus Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gieder Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gieder Maddox (Address) 1112 Thompson St

15 FEB 9 1921 [redacted] Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, and TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 8 - 1921

17

I HEREBY CERTIFY, That I attended deceased from 2 - 7 - 1921, to 2 - 7 - 1921, that I last saw h Ex alive on 2 - 7 - 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 6 days.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? No

(Signed) Sol. C. Nuttall, M. D.

2/8 1921 (Address) 116 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 9 1921
20 UNDERTAKER	ADDRESS
Dove Robert A Elliott	1725 Ashland Ave

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

D50678 HEALTH DEPARTMENT—CITY OF BALTIMORE D50678

119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 114 Seldner St. ST.: 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Carroll.(C)

(Residence in Baltimore: No. 114 Seldner St.

5 ---------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, ... Do not know. (Month) ....., 1 (Day) ..... (Year)

7-AGE, 36 yrs. ---------- mos. ---------- ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. ..... wD
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), North Carolina.

PARENTS.

10-NAME OF FATHER, Robert Carroll.(C)

11-BIRTHPLACE OF FATHER (State or Country), Tennessee.

12-MAIDEN NAME OF MOTHER Dicey Davis.(C)

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Julia Williams(C)sister...

(Address).....114 Seldner St.....

15- FEB 9 - 1921 1921 Filed ..... Burial Permit Clerk Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... February 7th. 1921. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquiry.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
inquiry .....find that said deceased came to .her death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....
.....Acute Nebritis.....
.....
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) ..... Uraemia.....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Eisenhardt M. D.
(Coroner.)

Feb. 8th 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Feb 9, 1921
20-UNDERTAKER M C Doyle	ADDRESS 15 E Lee St

Spec.—8-24-14—M. & T.—2000 Bks.

D50679 HEALTH DEPARTMENT—CITY OF BALTIMORE D50679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 White St.; 20 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Smith

(Residence in Baltimore: No. 1926 White St.; 12 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	married

6-DATE OF BIRTH, June (Month) 21 (Day), 1875 (Year)

7-AGE, 45 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

037

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Aaron Patterson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Ann Turner

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Smith (husband)

(Address) 1926 White St.

15 FEB 9-1921 ROBERT B. BEAUTER Registrar.

Filed....., 191.... Burial Permit Issued

N. B.—Every item must be answered in plain terms, so that it may be understood by any one reading it. Do not use "do," "same," or "ditto," but repeat the word. Be particular and accurate in every statement, especially in regard to CAUSE OF DEATH in plain terms, so that it may be understood by any one reading it. Do not use "do," "same," or "ditto," but repeat the word. Be particular and accurate in every statement, especially in regard to CAUSE OF DEATH which is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 9 1921, to February 7 1921, that I saw her alive on February 7 1921, and that death occurred, on the date stated above, at 10.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration)....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary) Organic heart disease

(Duration) yrs. 2 mos. — ds.

(Signed) Chester Piland, M. D.

2-8-, 1921. (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Feb 9, 1921
20-UNDERTAKER Daniel Easton	ADDRESS Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

050680 HEALTH DEPARTMENT—CITY OF BALTIMORE 050680

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 570 W Preston ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Stanard

(a) RESIDENCE. No. 570 W. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Bertha Stanard

6 DATE OF BIRTH (month, day, and year) Unknown 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm A. Stanard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertha Stanard
(Address) 570 W Preston St

15 FILED FEB 9 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1920, to Feb 6, 1921, that I last saw him alive on Feb 5, 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. V. Fitzgerald, M. D.

2/9, 1921 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Feb 9 1921
20 UNDERTAKER	ADDRESS
Daniel J. Hemsley	W. Balto

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Kummer

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 050681

050681

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 Maryland Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Kummer

(Residence in Baltimore: No. 635 Maryland Ave St.; 39 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 20, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 10 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Koch.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Kaufmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Koenig

(Address) 627 Maryland Ave

15- FEB 9 - 1921 1921. Burial Permit Clerk
Filed ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 30 1921, to Jan 31 1921, that I saw h[illegible] alive on Jan 31 1921, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Feb 6 P, 1921. (Address) 701 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, Feb 9, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave

CAUSE OF DEATH. See instructions on back of certificate. important.

6 Spec.—8-24-14—M. & T.—2000 Bks.

D50682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50682

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5808 York Road ST.; 27 48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Maggie M. Hutson

(Residence in Baltimore: No. 5808 York Road St.; 69 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... Jan 6 ....., 1872
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
49 yrs. 1 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 469

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm H Hutson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Scheff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm S Hutson

(Address)..... 6 S. W. Carey

15-

Filed FEB 9 - 1921 191.... ROBERT I. GRAUTER Registrar.

Burial Permit Given

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb 6 1921 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Feb 6 1921, that I saw her alive on Feb 5 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Arthritis .....

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... John H Grotzinger M. D.

Feb 7 1921 (Address) 3101 Hartford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel	Feb 9, 1921
20-UNDERTAKER Pirkler & Pirkler	ADDRESS 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

050683

HEALTH DEPARTMENT—CITY OF BALTIMORE

050683

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 Milton Ave ST.: 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustavus Rudiger

(a) RESIDENCE. No. 1042 N. Milton Ave ST., 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rudiger

6 DATE OF BIRTH (month, day, and year) Oct 5, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Carpenter 1 0/b

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER George Rudiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Rudiger

(Address) 1042 Milton ave

15 Filed FEB 9 - 1921, 19.... ROBERT B. FLATTER Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Do not use abbreviations or technical terms. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 7, 1921, that I last saw h[illegible] alive on Feb 7, 1921, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) T. R. Henderson M. D.

Feb 8 1921 (Address) 1301 N Rut R K

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Feb 11 1921
20 UNDERTAKER Finkler & Finkler	ADDRESS 1739 Eager

Spec.—8-24-14—M. & T.—2000 Blks.

050684

HEALTH DEPARTMENT—CITY OF BALTIMORE

050684

CERTIFICATE OF DEATH.

REGISTERED NO. C 1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3724 Eastern ave ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul R Bennett

(Residence in Baltimore: No. 3724 Eastern ave St.; 2/3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. May 13, 1920
(Month) (Day) (Year)

7-AGE. ....yrs. 9 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Raphael J Bennett

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Lula Benson

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raphael J Bennett

(Address) 3724 Eastern Ave

15- FEB 9 - 1921 ROBERT P. PRAUTER

Filed ....., 191.... Registrar

Burial Permit Issued

CAUSE OF DEATH must be stated in all cases. See instructions on back of certificate. Information required is important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. February 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 1 1921, to February 7 1921, that I saw him alive on February 7, 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

.....Ileo-Colitis.....

..... (Duration) .....yrs. .....mos. 20 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Allen C Beethem M. D.

Feb'y 8, 1921 (Address) 3139 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. Feby 9, 1921

20-UNDERTAKER Robt Johnson ADDRESS 1442 W Balto

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

050685 — 43 — 050685

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1823 W. Balto. St. St. 19 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ella Krebs Lindemeyr

(Residence in Baltimore: No. 1823 W. Balto. St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April 1—, 1867 (Month) (Day) (Year)

7 AGE: 53 yrs. 10 mos. 7 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. L. Rathell

11 BIRTHPLACE OF FATHER (State or country): Talbott Co. Md.

12 MAIDEN NAME OF MOTHER: Krebs

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip Lindemeyr per. M.D.

(Address) 1823 W. Balto. St.

15 Filed FEB 9 - 1921 ROBERT B. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec — 8 —, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22—, 1918, to Dec 8—, 1921, that I saw her alive on Jan 30—, 1921, and that death occurred, on the date stated above, at 12.35 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of R. Breast

(Duration) 2 yrs. 2 mos. 17 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. M. Lindemeyr M.D. DR. J. CHAS. BUNCH

FEB 9 '21 191 (Address) 1823 W. Balto. St. PROFESSIONAL BUILDING

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Feb. 10, 1921

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Balto St.

N. B.—Every item of information should be carefully supplied. ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050686 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050686

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 65 Wilhelm Ave. ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Blum

(a) RESIDENCE. NO. 65 Wilhelm Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3" 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clarence J. Blum

11 BIRTHPLACE OF FATHER (city or town) Catonsville (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Spindler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Clarence J. Blum (Address) 65 Wilhelm St.

15 Filed FEB 8 1921 ROBERT P. BRADLEY Registrar Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that a person not a physician may understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7" 1921

17 I HEREBY CERTIFY, That I attended deceased from February 6 1921, to February 7 1921, that I last saw her alive on February 7 1921, and that death occurred, on the date stated above, at 9.35 Pm.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert E. Ryland, M. D.

Feb 8 1921 (Address) 215 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb 9 21
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D5068) HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D50687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1271 Battery Ave ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kirby.

(a) RESIDENCE. NO. 1271 Battery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Mulatto	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Kirby.

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48	—	—	.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Genl

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary Preston
(Address) 1271 Battery Ave

15 Filed FEB 9 - 1921, 19.. ROBERT J. BRAUTEN Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to Feb 8, 1921, that I last saw h alive on Feb 8, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. W. Wells, M. D

Feb 9, 1921 (Address) 1779 Williams Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill.	2-10 1921
20 UNDERTAKER	ADDRESS
E and B. Hasle	1156 Mass

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Do not use abbreviations or technical terms. Information desired in every case. Be sure to answer every question. Write plainly with pen and ink. Use figures for dates. Do not forget to sign certificate. Information required by law. Please read carefully the instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

050688 HEALTH DEPARTMENT—CITY OF BALTIMORE 050688

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1319 St. Paul St.; 25 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Bell Kehs

(Residence in Baltimore: No. 1319 St Paul St. St.; 12 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 29, 1874 (Month) (Day) (Year)

7-AGE, 47 yrs. mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, John Braboch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Matilda Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Kehs

(Address) 1319 St Charles St

15-

Filed FEB 9 - 1921 191.....

ROBERT B. ARMSTRONG
Chief Bureau of Vital Statistics
Registrar.

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Feb 7 1921, that I saw h alive on Feb 7 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. 2 mos. ds.

(Signed) R. E. Campbell M. D.

Feb 7, 1921 (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross C. A. Co. DATE OF BURIAL, 2-11..., 1921

20-UNDERTAKER E and B Hasle ADDRESS 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

h050689 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 h050689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Daly, Dailey

(a) RESIDENCE. No. Preston & Valley Sts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX (Male / Female) Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Clark.

6 DATE OF BIRTH (month, day, and year) April 10 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER George Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Finnaly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence. (Address) Preston & Valley

15 Filed FEB 9-1921 ROBERT S. ARAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 6, 1921, to Feby 7, 1921, that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 2 P. ....m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Dame, M. D.

Feby 7, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A C — DATE OF BURIAL 2-10 1921

20 UNDERTAKER Edw B. Harle 116 E Worth — ADDRESS

So 585

CAUSE OF DEATH in plain terms. Abbreviations not allowed. Indefinite terms, such as Paralysis, Heart Disease, Cancer, Tumor, Abscess, Consumption, Old Age, Infantile Debility, Convulsions, Fever, Cold, Pneumonia, Bronchitis, Meningitis, Hemorrhage, Blood Poisoning, Septicemia, Uremia, Asthenia, Exhaustion, Suffocation, Collapse, Coma, Shock, Tuberculosis, Malignant Disease, Carcinoma, Sarcoma, Pyemia, Gangrene, Ulceration, Hernia, Intussusception, Stricture, Obstruction, Rupture, Injury, Accident, Suicide, Homicide, Drowning, Asphyxia, Burns, Scalds, Fractures, Contusions, Wounds, Lacerations, Internal Injuries, Poisoning, Abortion, Childbirth, Puerperal Septicemia, Puerperal Fever, Puerperal Convulsions, Puerperal Hemorrhage, Puerperal Accidents, Puerperal Abscess, Puerperal Peritonitis, Puerperal Phlebitis, Puerperal Thrombosis, Puerperal Embolism, Puerperal Pyemia, Puerperal Septicemia, Puerperal Uremia, Puerperal Eclampsia

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 E Cross St.: 24 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Folsom

(a) RESIDENCE. No. 128 E Cross ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Elmer Folsom

6 DATE OF BIRTH (month, day, and year) June 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elmer Folsom

(Address) 128 E Cross St

15 Filed FEB 9 - 1921 ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 3 1921 to Feb 6 1921, that I last saw h[er] alive on Feb 5 1921, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) Wm E Sigler, M. D.

2/8. 1921 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	2-9th 1921
20 UNDERTAKER	ADDRESS
E and B Stark	115 E Balto St

CAUSE OF DEATH in plain terms, so that it may be readily understood. Do not use abbreviations or initials. Consult the list on back of certificates. TION is very important. See instructions on back.

D50691 HEALTH DEPARTMENT—CITY OF BALTIMORE D50691

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2511 Salem ST.: 13 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton E. Burch

(Residence in Baltimore: No. 2511 - Salem St. (6 yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. (Month) 14 (Day), 1898 (Year)

7-AGE. 23 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.R.R. Co.

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. Frank M Burch

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Louisa Crow

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa C. Burch

(Address) 2511 Salem St.

15- Filed FEB 9 - 1924, 191..... ROBERT B KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 7 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Lungs. Pr. Tub. 7 03

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Thorrensen M. D.
(Coroner.)

Feb 8 1924 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Feb 9 1924

20-UNDERTAKER Josiah Lyford & Son

ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of important. See instructions on back of certificate.

Spec.—6-9-10—H. P. Co.—1000 Bks.

D 50692 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50692

CERTIFICATE OF DEATH.

X 108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henry Anna McLean.

(a) RESIDENCE. No. Edain Road & Elm Ave. Overlea ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm W. McLean

6 DATE OF BIRTH (month, day, and year) August 27 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Follers

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gilland

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Wm W. McLean
(Address) Overlea Md.

15 Filed FEB 9 1921 19 ROBERT E. LRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1921 to Feb. 8th 1921
that I last saw h[illegible] alive on February 8th 1921
and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis some

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 21st 1921

Was there an autopsy? No

What test confirmed Diagnosis?

(Signed) J. A. Schumacher M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hiss Cemetery	Feb. 11th 1921
20 UNDERTAKER	ADDRESS
Frederick Lissau & Sons	Fullerton Md.

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Appendicitis

Spec. 6-9-19 H. P. Co.- 1000 Bks.

D50693 HEALTH DEPARTMENT—CITY OF BALTIMORE D50693

CERTIFICATE OF DEATH. 30

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Buckingham.

(a) RESIDENCE. NO. 2025 Frederick Ave ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Edw. F. Buckingham

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Knopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Buckingham
(Address) 2101 Eutaw Place

15 Filed FEB 9 - 1921 19 ROBERT A. LAJTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9 1921

17 I HEREBY CERTIFY, That I attended deceased from February 2 1921, to February 9 1921, that I last saw him alive on February 9 1921, 3.30 P.m. and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture.

(Signed) W. F. Roy Lumpkin, M. D.

2/9. 1921 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Feb. 10 1921

20 UNDERTAKER Geo. L. Conrad & Bro — ADDRESS 2101 Eutaw

mation sought be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D50694 HEALTH DEPARTMENT—CITY OF BALTIMORE D50694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1801 n. Durbom ST.; 8 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine nee Donaughy

(Residence in Baltimore: No. 1801 ~~East~~ n. Durbom St.; yrs., 58 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 1st (Month) (Day), 1853 (Year)

7-AGE, 63 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Grocery

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth West

(Address) 1801 n. Durham

15- Filed FEB 9 - 1921, 191. ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Smiley M. D.
(Coroner)

2-8-21, 191.. (Address) M. C.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....,yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Co. | DATE OF BURIAL, Feby 12, 1921

20-UNDERTAKER Philip Herwig | ADDRESS 216 Adams

N. B.—Every item of information must be given, so that it may be properly classified. Each statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050695 HEALTH DEPARTMENT—CITY OF BALTIMORE 050695

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Luzerne ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly F. Pasterfield

(a) RESIDENCE. No. 224 N. Luzerne ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13-58

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework all

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm H. Pasterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha A. Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Nettie F. Curry 224 N. Luzerne

15 Filed FEB 9 - 1921 [illegible] Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Feb 6, 1921, that I last saw her alive on " " 1921, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Bauer, M. D.

(Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Feb 8 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Bond ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Blankman

(a) RESIDENCE. No. 27 S. Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Blankman

6 DATE OF BIRTH (month, day, and year) Aug 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 yrs	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Blankman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Louis (Address) 141 E. Baltimore St.

15 Filed FEB 9 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to Feb. 8, 1921, that I last saw him alive on Feb. 8, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Asthma Emphysema Chronic Bronchitis Myocarditis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Fibrosis Myocardial

Arteriosclerosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & history

(Signed) Frank R. Smith, M. D.

, 19 (Address) 917 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest, Dalb	Feb. 9 1921
20 UNDERTAKER	ADDRESS
Jack Levin	141 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone not sufficient. Omission of important facts may be prejudicial to interests of family. Certificate should be filled out in every case, whether physician was in attendance or not. Physician should sign certificate and state time and place he last saw deceased alive. Coroner should not sign certificate unless he has viewed the body or has made an inquest. Midwife should not sign certificate unless she has been in attendance at the birth. Undertaker should not sign certificate unless he has embalmed the body or has the certificate of a physician, coroner or midwife as to the cause of death. Certificate should be signed by person having knowledge of the facts. Certificate should be written in ink or typewritten. Certificate should be delivered to undertaker or person in charge of burial. Burial permit will not be issued unless certificate is properly filled out. Certificate must be returned to Registrar of Vital Statistics before burial permit will be issued. Penalty for violation of any of the above provisions, $5.00 to $50.00. See instructions on back of certificates.

D50697 HEALTH DEPARTMENT—CITY OF BALTIMORE D50697

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3711 Eastern Ave ST. 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio Sergi

(Residence in Baltimore: No. 3711 - Eastern Ave St.; yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, 11/12/1920, 1 (Month) (Day) (Year)

7-AGE, — yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Dominic Sergi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Parisi

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominic Sergi

(Address) 3711 - Eastern Ave

15- ROBERT J KRAUTER

Filed FEB 9 - 1921 19... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/8/21, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. d

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. d

(Signed) Stewart F Edwards M. D.

(Coroner)

, 19.., (Address) 1800 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...d

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, 2/9/21, 19...

20-UNDERTAKER Geo J. Ruth ADDRESS 1735 Hanford ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50698

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1142 n Stockton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Elizabeth Carter

(a) RESIDENCE. No. 1142 n Stockton ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Moses Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Glover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Carter
(Address) 1142 n Stockton

15 Filed FEB 9 - 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb 8, 1921, that I last saw h alive on Feb 8, 1921, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

2/8, 1921 (Address) 2008 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cmty	Feb 10 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Bks.

D 50699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50699

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1011 N. Arlington ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Kohlsmeed

(Residence in Baltimore: No. 1011 N Arlington Ave St.; 57 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 28, 1863 (Month) (Day) (Year)

7-AGE, 57 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Francis H. Kohlman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louisa Kusymaul

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Mantman

(Address) 1011 N. Arlington Ave

15- Filed FEB 9 - 1921 191... ROBERT E. LEAUTER Registrar of Vital Statistics

Observe directions on back of certificate. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 8th, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 2d 1921, to Feby 8th 1921, that I saw h[er] alive on Feby 7th 1921, and that death occurred, on the date stated above, at 1:00 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) D. K. Brwale M. D.

Feb 10, 1921. (Address) 1817 N Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... moc. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb. 10, 1921.

20-UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50700 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50700

CERTIFICATE OF DEATH. 4 X 91-069

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 214 N Greene ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edwin Adams

(a) RESIDENCE. (Usual place of abode) No. 214 N Greene ST., WARD. Cumberland Md

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ivy Adams

6 DATE OF BIRTH (month, day, and year) April 12-47

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bedford Pa.

PARENTS

10 NAME OF FATHER Uriah Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Charles B Rayson (Address) 214 N Greene St

15 Filed FEB 9 - 1921 ROBERT P. [illegible] Registrar

Burial Permit Issued

CAUSE OF DEATH to plain terms, so that a TION is very important. See instructions on b

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1921 to Feb 8 1921, that I last saw him alive on Feb 8 1921, and that death occurred on the date stated above, at 345 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank R McGowan M. D.

Feb 1924 (Address) 322 N Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md

DATE OF BURIAL Feb 9 1921

20 UNDERTAKER W M Routson

ADDRESS 230 N Greene

Spec.—8-24-14—M. & T.—2000 Bks.

1050701 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Park ave ST.; 11 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Pratt

(Residence in Baltimore: No. 1026 Park ave St.; 38 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January, 1, (Month) (Day) (Year)

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Lewis Payne

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah a Roberson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B Payne

(Address) 1026 Park ave

15- FEB 9 - 1921 ROBERT B CRAUTER Filed ... 191.. Burial Permit Granted ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13th 1920, to July 6th 1921, that I saw h er alive on July 6th 1921, and that death occurred, on the date stated above, at 130 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diphtheria

(Duration) 2 yrs. mos. 10 ds.

(Signed) Chas. J. Miller M. D.

July 8, 1921 (Address) 222 Wilson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mt auburn — DATE OF BURIAL, Feb 9th, 1921

20-UNDERTAKER H.W. Pye — ADDRESS Edmondson ave

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations or technical terms. Consult physician if necessary. Omission to answer any of the above questions will delay burial. See instructions on back of certificate.

Chojnowski

Spec.—6-9-19—H. P. Co.—1000 Bks.

050702 HEALTH DEPARTMENT—CITY OF BALTIMORE 050702

CERTIFICATE OF DEATH. 151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. No. 1710 Aliceanna ST.; W WARD)

2-FULL NAME Joseph Chojnowski

(a) RESIDENCE. No. 1710 Aliceanna ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Marr

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Chojnowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Adela Bluszanez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Bluszanez 1710 Aliceanna

15 Filed FEB 9 - 1921 ROBERT J. KRAUTER Registrar Social Security Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1921, to Feb 9 1921,

that I last saw him alive on Feb 9 1921,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Irritation Bowels

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. J. Bryant, M. D.

2/9/21 (Address) 1611 Kennedy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 9 1921
20 UNDERTAKER John F. Weber	ADDRESS 1603 Bank St

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

3710

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50703 HEALTH DEPARTMENT—CITY OF BALTIMORE D50703

CERTIFICATE OF DEATH. X 91-078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N. Broadway ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Freno Jr.

(a) RESIDENCE. No. 1304 N. Broadway ST., WARD. Hinton W Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20 or 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Hinton
(State or country) W. Va

PARENTS

10 NAME OF FATHER John A. Freno

11 BIRTHPLACE OF FATHER (city or town) Wyoming
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Virginia Rutherford

13 BIRTHPLACE OF MOTHER (city or town) Ronceverte
(State or country) W. Va

14 Informant John A. Freno Sr.
(Address) 1304 N. Broadway

15 Filed FEB 9 - 1921 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to Feb. 5, 1921, that I last saw him alive on Feb 5, 1921, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Incompetency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho. Pneumonia acute

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromshas, M. D.

2-8, 1921 (Address) 615 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 10 1921
20 UNDERTAKER	ADDRESS
Frank A. Fink	910 W. Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Bks.

2050704 HEALTH DEPARTMENT—CITY OF BALTIMORE 2050704

CERTIFICATE OF DEATH.

REGISTERED No. C 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 E. 36th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Emma Follett

(Residence in Baltimore: No. 637 E 36th St.; — yrs., — mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, February 6, 1921.
(Month) (Day) (Year)

7-AGE, — yrs. — mos. — ds. If LESS than 1 day, 1 hrs. or — min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Clarence Gallett

11-BIRTHPLACE OF FATHER (State or Country), Harrisonburg Va.

12-MAIDEN NAME OF MOTHER, Emma B. Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence W Gallett

(Address) 637 E. 36th St.

15- ROBERT J KRAUTER

Filed FEB 9 1921 191 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1921, to Feb 8 1921, that I saw her alive on Feb 8 1921, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(About 8 months)

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) John S. Fenby M. D.

2/9, 1921. (Address) 3520 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Feb 10 1921
20-UNDERTAKER	ADDRESS
P. Henry Lutz	1007 Bond St.

CAUSE OF DEATH must be plainly stated. All questions should be answered. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah Montague.

(a) RESIDENCE. No. 400 Pine St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 FILED FEB 9-1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1921, to February 7, 1921, that I last saw him alive on February 7, 1921, and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) W. B. Herman M. D.

2/7/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER: Commissioner Health,	ADDRESS FEB 9 1921

IT IS CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50706

X 114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hosp. ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A Bankert.

(a) RESIDENCE. No. Littlestown Pa ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Mary Bankert

6 DATE OF BIRTH (month, day, and year): Apr 30-1858

7 AGE: Years 62 Months 9 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Christian Bankert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Blubaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Herbert Bankert Littlestown Pa

15 Filed EB 9-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 8. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23. 1921, to Feb. 8, 1921, that I last saw him alive on Feb. 8, 1921, and that death occurred, on the date stated above, at 2 50 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Pulmonalis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Acute Cardiac dilitation

(duration) ..... yrs. ..... mos. 3 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan. 24, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Manifestations

(Signed) Ruth Richardson, M. D.

(Address) Md Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Littlestown Pa.	2/9/21 19
20 UNDERTAKER: Chas Eppert Son.	ADDRESS 118 W Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

D. 50707 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50707

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 414 Pearl st ST.: 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mr. A. Caulk,

(Residence in Baltimore: No. 213 W. Franklin St. 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Dec 25, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shop Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Wm. G. Caulk

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Kirby

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen McSpaden

(Address) 811 E. 22nd St

15- Filed ....., 191.... Robert P. Harrison,
Registrar.
Burial Permit Clerk.

FEB 9 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
(Duration) a few hours

CONTRIBUTORY (Secondary) Don't know of any
(Duration) ....yrs. ....mos. ....ds.

(Signed) W. R. Gonzales M. D.
(Coroner.)

2-9, 1921 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine	Feb 10, 1921
20-UNDERTAKER William Cook	ADDRESS 502 E. Pattons

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50708

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 N Lee ST. [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred V. Riley

(a) RESIDENCE. No. 650 N Lee ST. 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos E Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mabel V. May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thos E Riley (Address) 650 N Lee St

15 Filed FEB 9-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 5, 1921, to Feb 9, 1921, that I last saw h[illegible] alive on Feb 5, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchos Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell, M. D.

Feb 9. 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Feb 10th 1921
20 UNDERTAKER	ADDRESS
P Schlosser & Son	Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50709

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 770 W. Cross ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie B. Lentz

(a) RESIDENCE. NO. 770 W. Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Edward Lentz

6 DATE OF BIRTH (month, day, and year) May 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER James H. Stevens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary C. Sullivan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Indies

14 Informant Edward Lentz
(Address) 770 W. Cross St

15 Filed FEB 9 - 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1920, to Feb 8, 1921, that I last saw her alive on Feb 4, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

1 Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) J. Morley Strag, M. D.

2/8, 1921 (Address) 726 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 11 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50710 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore Genl. Hospital

CITY OF BALTIMORE (No. 1213 Light ST. 24 WARD)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Longest

(a) RESIDENCE. No. 1028 Riverside Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20, 1852

7 AGE — Years: 68 — Months: 9 — Days: 17 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Riverside Park

(c) Name of employer: Baltimore City

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: John Longest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Julia S. Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: South Balt. Gen. Hospital
(Address)

15 Filed FEB 9-1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1921, to Feb 6, 1921, that I last saw him alive on " " 1921, and that death occurred, on the date stated above, at 10 30 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Gen'l)
Coronary embolism.

(duration 4-5 yrs. mos. ds.)

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Howard L. Foley, M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hereford Md — DATE OF BURIAL: Feb 13 1921

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50711 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 E Cross ST. 24 WARD) REGISTERED No. C 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B Douglass

(Residence in Baltimore: No. 121 E Cross St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 3 (Day) 1840 (Year)

7-AGE, 72 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mariner do.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Westmoreland Co. Va

PARENTS.

10-NAME OF FATHER, Lemuel Douglass

11-BIRTHPLACE OF FATHER (State or Country), Westmoreland Co. Va

12-MAIDEN NAME OF MOTHER Frank E Brinnon

13-BIRTHPLACE OF MOTHER (State or Country), Westmoreland Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine B Douglass

(Address) 121 E Cross St

15-

Filed ..... 191.. Robert P. Harris ..... Registrar.

Feb 9 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 9 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1919, to Feb 9 1921, that I saw him alive on Feb 8 1921, and that death occurred, on the date stated above, at 1:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter L Denny M. D.

Feb 9, 1921. (Address) 3517 Fairview Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem. DATE OF BURIAL, Feb 12, 1921.

20-UNDERTAKER John L Denny ADDRESS 715 Light St

CAUSE OF DEATH must be filled in. Physician will be required to report cause of death when important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50712 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSP. #56 REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. St. 24 28 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JAMES S. QUANDER

(a) RESIDENCE. No. US? PUBLIC HEALTH SERVICE HOSP. #56 WARD. 30
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Kate Quander

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
29	yrs.	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ********

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbuck Registrar (Address) Fort McHenry Baltimore Md.

15 Filed FEB 9 - 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH, (month, day, and year) Feb. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from November 1. 1920. to February 8, 19 21, that I last saw him alive on Feb. 8. 1921, and that death occurred, on the date stated above, at 2'50 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far advance & active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne M. D.

, 19 (Address) Fort McHenry Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. DATE OF BURIAL Feb 9, 1921

20 UNDERTAKER S. Simpson & Bro ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Extra sheet may be used if necessary. Attention is invited to the back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50713 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50713

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH US. PUBLIC HEALTH SERVICE HOSPITAL 756

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD. ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HENRY D. HOLLOMAN

(a) RESIDENCE. No. US. PUBLIC HEALTH SERVICE HOSPITAL 756 WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
19	yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) -------

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Edgar T. Rinehart Registrar

(Address) Fort McHenry Baltimore Md.

15 Filed FEB 9-1921, 19 ROBERT P. HARLEE, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1921

17

I HEREBY CERTIFY, That I attended deceased from February 4 1921, to February 8 1921, that I last saw him alive on Feb. 8 1921, 19, and that death occurred, on the date stated above, at 12'15 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho

(duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? Yes

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Payne, M. D.

, 19 (Address) Fort McHenry Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pachuta, Miss	Feb 9 1921
20 UNDERTAKER	ADDRESS
A. Leinson & Bro	E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact address of occurrence is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50714

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wm. Hosp. St. 13 Ward)

2-FULL NAME Pvt. Edward L. Beauchamp.

(a) RESIDENCE. No. 1620 W. North Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ina Beauchamp.

6 DATE OF BIRTH (month, day, and year) May 1, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician 0/8

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm Beauchamp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edna Trull Beauchamp

(Address) 1620 W. North Ave

15 Filed FEB 9-1921 Robert P. Harrison, Registrar

[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1921

17

I HEREBY CERTIFY, That I attended deceased from 1/18, 1921, to 2/7, 1921, that I last saw h[illegible] alive on 2/7, 1921, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/19/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis L. Polk, M. D.

2/7, 1921 (Address) Med. Dept.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 10 1921
20 UNDERTAKER	ADDRESS
Wm Tickner & Sons	North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50715

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Warwick ave ST.; 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Jackson Linthicum

(Residence in Baltimore: No. 1635 Warwick Ave St.; 58 yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, January 5, 1863 (Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Slayden Linthicum

11-BIRTHPLACE OF FATHER (State or Country), Howard Co.

12-MAIDEN NAME OF MOTHER Virginia Spears

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Linthicum

(Address) 1635 Warwick Ave

15-

Filed FEB 9 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1919 191 , to Feb 8 1921 , that I saw h.. alive on Feb 8 1921 , and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) 2 yrs. mos. ds.

(Signed) W. Frick Guerbon M. D.

Feb 9, 1921 (Address) 1405 EDMONDSON AVE.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Feb 11, 1921

20-UNDERTAKER	ADDRESS
W. Frick Guerbon	Norbeck Pa

D.50716 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Mercy Hospital ST.: 3 WARD) 184

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Nauschuk

(Residence in Baltimore: No. 918 1/2 E. Fairmount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Russia Nauschuk

PARENTS.

10-NAME OF FATHER, F. Nauschuk

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Lena Fikoncuk

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grebliunas

(Address) 425 S. Paca St.

15- Robert P. Harrison,

Filed....., 191.....

FEB 9-1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or ~~inquiry.~~)
thereon and from the evidence obtained by said .....
(Inquest, au-
Inquest ..... find that said deceased came to .....death
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Ruptured Intestines

Inquest may be held 2:30 P.M. 2-10-21

1 Hour
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY. Gen. Health Pertonitis
(Secondary)
(Duration) .....yrs. .....mos. .....ds.

(Signed) M. Feldy M. D.
(Coroner.)
2-10-21, 1921. (Address) 18 S. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Feb. 10, 1921
20-UNDERTAKER	**ADDRESS**
John Grebliunas	425 S. Paca St.

N.B.—Every item of information should be carefully supplied. Please see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEC. 135

Kicked in the Stomach while in U.S. Navy
a Sailor.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50717 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.50717

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 S. Dond St ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Boyleau

(a) RESIDENCE. NO. 714 S Dond — ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Boyleau

6 DATE OF BIRTH (month, day, and year) nov 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Sofie Lauffaitis (Address) 637 S Pacas St.

15 Filed FEB 9-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8-21

17

I HEREBY CERTIFY, That I attended deceased from Feb 7- 1921, to Feb 8- 1921, that I last saw h-er alive on Feb 7- 1921, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis —

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Septic infection —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual —

(Signed) Dr. A. Brancato, M. D.

Feb 9 1921 (Address) 125 S Bloom —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislovas	Feb 11 - 1921

20 UNDERTAKER	ADDRESS
John Greblianskas	425 S. Pacas St

MEDICAL CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2050718

HEALTH DEPARTMENT—CITY OF BALTIMORE

2050718

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.: 23 74 Ward)

2-FULL NAME John Summers.

(a) RESIDENCE. No. 1030 Sharp St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Summers

6 DATE OF BIRTH (month, day, and year) Dec 18 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Market Master

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Feaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Summers (Address) 1030 Sharp St

15 Filed FEB 10 1921 ROBERT E. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased frum Dec. 28 1920, to Feb. 9 1921, that I last saw h~~im~~ alive on Feb 9 1921, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1/4/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. B. McElwain, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Humicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 14 1921
20 UNDERTAKER	ADDRESS 1034
E Schlosman & Son	Hanover

mation should be entered, especially as to exact statement of DECEASED'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Would not Permit Autopsy
Could give no further history

1050719 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050719

CERTIFICATE OF DEATH. 156

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 602 Aisquith St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John P. Fogarty

(Residence in Baltimore: No. 602 Aisquith St.) St.: yrs. mos. ds.)

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 8 (Month) (Day) 1 (Year)

7-AGE, 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nicholas Fogarty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Kehoe

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brey

(Address) 1406 E. Biddle St

15- Filed FEB 10 1921 191 ROBERT B. KRAUTER Registrar Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 7 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illness of 3 Months Duration

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

2-9, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cemetery	Feb 11, 1921
20-UNDERTAKER Harry Hooke & Son	ADDRESS 1301 E. Eager St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D50720 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50720

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1011 N. Calvert St ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Telfair McKim

(a) RESIDENCE. No. 1011 N. Calvert St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Feb 22nd 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John S McKim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katharine L Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs John G Gardner (Address) W. Va

15 Filed FEB 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Feb 9, 1921, that I last saw her alive on Feb 8, 1921, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast —

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) Dr. B. Blumenau, M. D.

19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Feb 10 1921
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son	1900 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050721

HEALTH DEPARTMENT—CITY OF BALTIMORE

050721

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Saint Paul ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agnes Donellan

(Residence in Baltimore: No. 922 Saint Paul St.: — (yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, September (Month) 15th (Day), 1870 (Year)

7-AGE, 50 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Has been an invalid
(b) General nature of industry, business, or establishment in which employed (or employer): 6 years

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, James Donellan

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Katharine ——

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Donellan

(Address) 922 St. Paul St.

15-FEB 10 1921 ROBERT I KRAUTER

Filed....., 191.....

Burial Permit Register.

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 7th (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 29th, 1920, to February 7th, 1921, that I saw h[illegible] alive on December 26th, 1921, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(15 days) (Duration)....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration)....yrs.....mos.....ds.

(Signed) Edw. S. Perrin M. D.

Feby 7th, 1921. (Address) 1W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Feb. 10, 1921
20-UNDERTAKER	ADDRESS
J. J. Fahey & Son	1318 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50722 HEALTH DEPARTMENT—CITY OF BALTIMORE D50722

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2512 Guilford Avenue St.: 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frederick Daley

(a) RESIDENCE. No. 2512 Guilford Avenue St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Muschette

6 DATE OF BIRTH (month, day, and year) April 27, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Financial Editor

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Sun

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis F. Daley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Julia A. Wells

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know

14 Informant Charles M. Daley
(Address) 2512 Guilford Avenue

15 Filed FEB 10 1921, 19 ROBERT J. CRAWFORD
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19" 1920 to Feb 9, 1921, that I last saw h[illegible] alive on Feb 8, 1921, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? physical Ex

(Signed) Henry B. Mowell, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	2/11 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last Birthday must be given. Full information should be entered in all blanks. Use back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050723

HEALTH DEPARTMENT—CITY OF BALTIMORE

050723

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1133 W Lombard ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj. F Cook

(a) RESIDENCE. NO. 1133 W Lombard ST. 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 086

(b) General nature of industry, business, or establishment in which employed (or employer) Blumers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Benjamin M. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs H Cook

(Address) 1133 W Lombard

15 Filed FEB 10 1921 19 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 - 19 21, to F. 9 19 21, that I last saw h[illegible] alive on Feb 8 - 19 21, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

Over

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F A Wesnaka M. D.

2/10. 1921 (Address) 1307 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	F 23d 19 21
20 UNDERTAKER	ADDRESS
John L Fields	1200 W Lombard

MAKE Sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The Patient had had Hic-
cough which cleared up.
He had a Myocarditis
for some time.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50724 HEALTH DEPARTMENT—CITY OF BALTIMORE D50724

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S. 16. St. 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bodine.

(a) RESIDENCE. No. 519 S 16 St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 8. 1920

7 AGE: Years — Months 8 — Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Bodine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Minnie Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm Bodine (Address) 519 S 16 St

15 Filed FEB 10 1921 ROBERT B. BRUCE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 1921, to Feb. 8, 1921, that I last saw h[illegible] alive on Feb. 8, 1921, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia. — (duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Syncope. — (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Feb. 9. 1921 (Address) 3505 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Feby 10 1921

20 UNDERTAKER: John Herwig & Co

ADDRESS: 2808 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Blks.

146136 D50725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50725 109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Cousins

(a) RESIDENCE. NO. 1615 E. Eager St. City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ James M. Cousins (Father).

6 DATE OF BIRTH (month, day, and year) Dec. 27. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housemaid.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James M. Cousins.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Gaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Johns Hopkins Hosp. Nurse.

15 Filed FEB 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1921, to Feb. 9, 1921.

that I last saw her alive on Feb. 9, 1921,

and that death occurred, on the date stated above, at 11:58 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2-3 ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis

(duration) yrs. mos. 2-3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb. 9 1921.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation & Autopsy

(Signed) H. Bluedale, M. D.

2-10, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemty.	Feb 12 1921
20 UNDERTAKER: Burkler & Birkler	ADDRESS 1739 Eager

mation should be carefully supplied, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

050726 HEALTH DEPARTMENT—CITY OF BALTIMORE 050726

CERTIFICATE OF DEATH. Arlington 17

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Reisterstown Rd & Academy Rd St.; Ward) 26

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Florence Dirkl

(Residence in Baltimore: No. Reisterstown Road & Academy ave St.; 56 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	Married

6-DATE OF BIRTH, Feb 23, 1864
(Month) (Day) (Year)

7-AGE, 56 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Skelly.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry H Dirkl

(Address) Reisterstown Rd & Academy ave

15- Filed FEB 10 1921, 191.... ROBERT P. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1921.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 17 1920, to Feb 8 1921, that I saw h[er] alive on Feb 8 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Uraemic Coma. Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Left Hip

(Duration) yrs. mos. ds.

(Signed) C. E. Nichols M. D.

Feb 8, 1921 (Address) Pikesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Feb 11, 1921.

20-UNDERTAKER J. F. Elsen — ADDRESS Reisterstown Md

(Coca)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

050727 HEALTH DEPARTMENT—CITY OF BALTIMORE 050727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 S. Highland Ave Ward 26 154 St. Veith - Veith)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene

(Residence in Baltimore: No. 109 S Highland Ave St.; 47 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 3 (Day), 1855 (Year)

7-AGE, 65 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Draftsman
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Navy Dept

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wilson

(Address) 109 S. Highland

15-

Filed FEB 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Harry Fisher M. D.
(Coroner.)

2-9-, 1921 (Address) 4 E. Lex St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Feb 10, 1921

20-UNDERTAKER Philip Herring — ADDRESS 206 Aliceanna

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--8-24-14—M. & T.—2000 Bks.

1050728

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050728

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 S Broadway St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Diering

(Residence in Baltimore: No. 1239 S. Broadway St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Write Word) Married

6-DATE OF BIRTH, March (Month) 31 (Day), 1861 (Year)

7-AGE, 54 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) 038

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Philip Diering

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Knopf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H Diering

(Address) 1239 S. Broadway

15-

Filed....., 191.... ROBERT J. HARTER Registrar.

FEB 10 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 7 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 1918, to Feb 7 1921, that I saw h alive on Feb 7 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Feb 7, 1921 (Address) 201 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery | DATE OF BURIAL, Feb 10, 1921

20-UNDERTAKER H. Allen Fuller | ADDRESS 3517 Springfield Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1050729

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050729

CERTIFICATE OF DEATH.

50

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 George Ave. Hamilton St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Snyder

(Residence in Baltimore: No. 101 George Ave Hamilton St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1856 (Year)

7-AGE, 64 yrs. 2 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Stein

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Holland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles A. Snyder

(Address) 101 George Ave Hamilton

15- Filed FEB 10 1921 ROBERT F. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Feb 8 1921, that I saw h[illegible] alive on Feb 8 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) George L. Lynch M. D.

Feb 9, 1921 (Address) 27 Harford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Feb. 11, 1921

20-UNDERTAKER Frank A. Fink — ADDRESS 915 N. Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50730 HEALTH DEPARTMENT—CITY OF BALTIMORE D50730

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 268 S. East Ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka Blimline

(a) RESIDENCE. No. 268 S. East Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Blimline

6 DATE OF BIRTH (month, day, and year) May 4, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Rode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Louis Blimline (Address) 408 S. 13th St.

15 Filed FEB 10 1921 ROBERT J. KLAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Feb. 8, 1921, that I last saw her alive on Feb. 7, 1921, and that death occurred, on the date stated above, at 7 20 A. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion
uraemic Coma

(duration) x yrs. x mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (duration) 2 yrs. x mos. x ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) J. C. L. Finlay, M. D.

(Address) 5480 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Lem.	Feb. 11 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet St.

mation should be carefully supplied. Age, sh... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on b... OCCUPA- Exact statement of ... may be properly classified. ... on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50731

CERTIFICATE OF DEATH.

79-041

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Hamilton Ave. St. Rospeburg 27 WARD)

2-FULL NAME Amelia A. Seidel

(a) RESIDENCE. No. W. Hamilton Ave. St. Raspeburg WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., If of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emerson H. Seidel

6 DATE OF BIRTH (month, day, and year): Jan. 25/1855

7 AGE: Years 66 Months 5 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Rochus Walz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Maria Heimerlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emerson H. Seidel
(Address) W. Hamilton Ave. Raspeburg

15 FEB 10 1921 ROBERT E. LEWIS Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 10, 1921, that I last saw h... alive on Feb 8, 1921, and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Regurgitation

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1921 (Address) 47 W. Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Feb. 12th 1921

20 UNDERTAKER: Mr. & Mrs John H. Teufel ADDRESS: 801 N. Fayette

mation should be carefully supplied. Any blanks should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—8-24-14—M. & T.—2000 Bks.

(August Bachmann)

D. 50732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50732

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 W. Conway ST.; 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aug. Bachmann

(Residence in Baltimore: No. 624 W. Conway St.; 54 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED?~~ (Write the word.) Widower

6-DATE OF BIRTH, Apr. (Month) 14th (Day) 1832 (Year)

7-AGE, 81 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 88
(b) General nature of industry, business, or establishment in which employed (or employer)..... Shoemaker

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Bachmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lillie Bachmann

(Address) 624 W. Conway St.

15- Robert P. Harrison,

Filed....., 191.....

Registrar.

FEB 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 9 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Feby 9, 1921, to Feby 9, 1921, that I saw h— alive on Feby 9, 1921, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) The Interstitial Nephritis

(Duration) yrs. 1½ mos. ds.

(Signed) John A. Madden M.D.

2-10, 1921. (Address) 638 Belvedere Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 624 W Conway St

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Feb 11, 1921

20-UNDERTAKER Philip Seward & Son ADDRESS 1825 W North ave.

N.B. Burial Permit cannot be issued by Registrar unless CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 15 28

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wilson

(a) RESIDENCE. NO. 1355 N. Carey st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Wilson

6 DATE OF BIRTH (month, day, and year): 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Frank Noel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Amanda Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ~~Unknown~~ Md

14 Informant: Hospital Records
(Address) M.T.H.

15 Filed FEB 10 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1920, to Feb. 9, 1921, that I last saw her alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 3.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Lo. D. Fahndrich. M. D.

2-9-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Feb 11 1921

20 UNDERTAKER: Hammel & Wright ADDRESS: 1364 N Carey

mation should be carefully supplied. AGE should be stated in the last birthday. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50734 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Sarah Ann ST.; 18 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Shipley

(a) RESIDENCE. No. 1031 Sarah Ann ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Arthur Burns

6 DATE OF BIRTH (month, day, and year): Nov 7, 1883

7 AGE: Years 37 | Months 3 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md Balto

PARENTS

10 NAME OF FATHER: William Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah Burrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Bertie Talley
(Address) 1031 Sarah Ann St

15 Filed FEB 10 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/8/1921

17 I HEREBY CERTIFY, That I attended deceased from 1/29/, 1921, to 2/8/, 1921, that I last saw h.e alive on 2/4/, 1921, and that death occurred, on the date stated above, at 2.10 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Heart Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Defect (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Hodell, M. D.

2/8/1921 (Address) 967 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb. 11 1921
20 UNDERTAKER	ADDRESS
Daniel Eagan	167

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D. 50735 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 337 W. Biddle St.; 11 WARD) 120

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Gardner

(Residence in Baltimore: No. 337 W. Biddle St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) (Day), 1877 (Year)

7-AGE, 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, John Garden

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary Willis

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Taylor

(Address) 1414 Division St.

15-

Robert P. Harrison,

Filed ..... 191.....

Registrar.

FEB 10 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Kennessy M. D.
(Coroner.)

Feb. 10. 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Feb 12 1921

20-UNDERTAKER Daniel Carton ADDRESS 916 Eastern Ave

D.50736 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50736

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 808 E. Fayette St ST.: 3 WARD) REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME David Michael

(Residence in Baltimore: No. 808 E. Fayette St St.; yrs., 6 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 4 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Maryland

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Maryland

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlton Valentine

(Address) 808 E. Fayette St

15- Robert P. Harrison, JOHNS HOPKINS HOSPITAL

Filed ....., 191.....

FEB 1 1921 Burial Permit Clerk. Registrar.

TO BE MORGUE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ekoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ford Rustin M. D.
(Coroner.)

Feb 9, 1921 (Address) 1505 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL, ... 19....

20-UNDERTAKER Commissioner Health ADDRESS FEB 1 1921

Per. Wm. E. WOODALL.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50737

CERTIFICATE OF DEATH.

164

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 N Madeira ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Kasik

(Residence in Baltimore: No. 931 N Madeira St.; 33 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1882 (Year)

7-AGE, 38 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jos. Skronicka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant. Skroun

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Em Kasik

(Address)..... 931 N. Madeira St

15-

Filed ..... 1921 Robert P. Harrison,

Registrar.

FEB 10 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 6 1921, to Feb 9 1921, that I saw h— alive on Feb 9 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

(a) Acute Indigestion

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Valvular

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. H. Reinecke M. D.

Feb 9 1921, (Address) 801 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Oak Hill — DATE OF BURIAL, Feb. 12, 1921

20-UNDERTAKER Smith Bros & Son — ADDRESS 1906 E Baltimore

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Probably due to ptomaine poisoning. Kind of food unknown.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50738

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2530 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine M. Poger

(Residence in Baltimore: No. 2530 McElderry St — St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec. (Month) 11 (Day), 1887 (Year)

7-AGE,	If LESS than 1 day,
33 yrs. 2 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Stramsky

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Matyska

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Poger

(Address) 2530 Mc Elderry St

15- FEB 10 1921 Filed ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1920, to Feb 8 1921, that I saw h.... alive on Oct 3 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

(a) .....

Pulmonary Tuberculosis

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. 1 mos. ....ds.

(Signed) W. S. Gerry M. D.

Feb 9, 1921. (Address) 6 E Preston Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Feb 12, 1921
20-UNDERTAKER Frank Erdelbon	ADDRESS 1906 Eutaw

D.50739 HEALTH DEPARTMENT--CITY OF BALTIMORE D.50739

CERTIFICATE OF DEATH +39

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Southern Hospital ST.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Perry Shriver

(Residence in Baltimore: No. Sinking Hospital St.: yrs. 7 mos. ds.)

WRITE PLAINLY, WITH INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Feb. (Month) 21 (Day), 1837 (Year)

7-AGE: 83 yrs. ... mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Railroad Employee
(b) General nature of industry, business, or establishment in which employed (or employer): 073

9-BIRTHPLACE (State or country): Pennsylvania

PARENTS

10-NAME OF FATHER: John Shriver

11-BIRTHPLACE OF FATHER (State or country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Rebecca Raver

13-BIRTHPLACE OF MOTHER (State or country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Shriver

(Address) Reisterstown, Md.

15- Robert P. Harrison, 191

REGISTRAR Burial Permit Clerk.

FEB 10 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb (Month) 10 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1920, to Feb 30 1921, that I saw h~~im~~ alive on Jan 30, 1921, and that death occurred, on the date stated above, at 12.10 m.

The CAUSE OF DEATH* was as follows:

Cancer of the Inferior Maxillae 2

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Flora Pallack M. D.

Feb 10, 1921. (Address) 1112 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. 7 mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence: Owings Mills Md.

19-PLACE OF BURIAL OR REMOVAL: Pleasant Hill - Md.

DATE OF BURIAL: 2/12, 1921

20-UNDERTAKER: Berryman Sons

ADDRESS: Reisterstown, Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50740 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50740

CERTIFICATE OF DEATH. 120-018

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 E Eager ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis R. Grant

(a) RESIDENCE. NO. 1834 E Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Isabella Grant

6 DATE OF BIRTH (month, day and year) Nov Known 1570

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter in Laundry
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Elite Laundry Balto, Md 086

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS
10 NAME OF FATHER Mark Grant
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Rachel Wheeler
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Isabella Grant
(Address) 1834 E. Eager St

15 Filed Robert P. Harrison, Registrar
FEB 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to Feb 9, 1921, that I last saw him alive on Feb 5, 1921, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis (duration) 4 yrs. 10 mos. ds.
CONTRIBUTORY (Secondary) Influenza (duration) 0 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 1834 E Eager St
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. E Thomas, M. D.
(Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Feb 13 1921
ADDRESS 147

20 UNDERTAKER Chas G Bailey Jefferson St

N. B.—WRITE PLAINLY. WITH UNFADING INK. AGE should be stated EXACTLY. If less than one year, DATE OF BIRTH should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50741 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50741

CERTIFICATE OF DEATH.

18-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 239 Loudon Avenue ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lucille Green

(a) RESIDENCE. No. 239 Loudon Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 18, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Clement S. Green

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Claire Callahan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Claire C. Green
(Address) 239 Loudon Avenue

15 Filed FEB 10 1921 Registrar

Burial Permit Issued

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 9th, 1921, that I last saw her alive on Feb, 19..., and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

1. Broncho Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) W. A. Knell, M. D.

2/10/19 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	2/10 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	105 W. Calvert St.

F. B.—WRITE PLAINLY. ALL information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

20.50742 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50742

CERTIFICATE OF DEATH.

REGISTERED NO. 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Chambers.

(a) RESIDENCE. No. 2002 McCulloh St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. Unknown mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Married.

5a If married, widowed, or divorced (or) WIFE of John Chambers.

6 DATE OF BIRTH (month, day, and year) Sept 25, 1888

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
32	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER George Coleman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant (Address) Johns Hopkins records

15 Filed FEB 10 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25th, 1920, to Feb 10, 1921, that I last saw her alive on Feb. 10, 1921, and that death occurred, on the date stated above, at 2-32 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix.
Broncho pneumonia

(duration) yrs. 3 mos. ds.,

CONTRIBUTORY (Secondary) Pyelitis & Endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Jan. 10, 1921

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) P. G. Dougherty, M. D.

2-10, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cmty	Feb 13 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 N. H. ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50743

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.50743

CERTIFICATE OF DEATH

H5

1 PLACE OF DEATH — Registered No. C

CITY OF BALTIMORE (No. 1000 N. 38th St. St. 13 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rev. Elwood James Renshaw

(Residence in Baltimore: No. 1000 N. 38th St. St. 3 yrs. 6 mos. – ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 29, 1860 (Month) (Day) (Year)

7 AGE: 60 yrs. 8 mos. 12 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Pastor
(b) General nature of industry, business, or establishment in which employed (or employer): Otterbein Mem. U. B. Church

9 BIRTHPLACE (State or country): Philadelphia, Pa.

PARENTS

10 NAME OF FATHER: Wm. E. Renshaw

11 BIRTHPLACE OF FATHER (State or country): Chester Co. Pa.

12 MAIDEN NAME OF MOTHER: Anna M. Miles

13 BIRTHPLACE OF MOTHER (State or country): Chester Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie E. Renshaw

(Address) 1000 N. 38th St.

15 Robert P. Harrison,

Filed FEB 10 1921 19[illegible] Burial Permit Issued REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 10, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920 to Feb 10 1921.

that I saw h[illegible] alive on Feb 9, 1921.

and that death occurred, on the date stated above, at 4 [illegible]9 m.

The CAUSE OF DEATH* was as follows:

Intra Pleural Hemorrhage

(Duration) ? yrs. mos. 21 ds

Contributory (SECONDARY) Cancer of Right Lung

(Duration) yrs. mos. ds.

(Signed) Stacy C. Algire M. D.

Feb 10, 1921 (Address) 3640 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lancaster, Pa. DATE OF BURIAL: Feb 14, 1921

20 UNDERTAKER: Horace Burgeer Son ADDRESS: 3631 Falls Rd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

20.50744 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2009 Girard Ave. ST.; 13 WARD) REGISTERED No. C 79

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R. Chambers

(Residence in Baltimore: No. 2009 Girard Ave. Se 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. 9, 1874 (Month) (Day) (Year)

7-AGE, 47 yrs. 1 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession or particular kind of work... Wholesale produce dealer
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Howard Co. Md.

PARENTS.

10-NAME OF FATHER, Charles Chambers

11-BIRTHPLACE OF FATHER (State or Country) Howard Co. Md.

12-MAIDEN NAME OF MOTHER Caroline M. Cross

13-BIRTHPLACE OF MOTHER (State or Country) Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth P. Chambers

(Address) 2009 Girard Ave.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

FEB 10 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ... M. D. (Coroner.)

(Address) 3622 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Lynn Ridge

DATE OF BURIAL, Feb. 12, 1921

20-UNDERTAKER Horace Burgee & Son

ADDRESS 363 Hall's Rd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-2-19—H. P. Co.—1000 Bks.

D.50745 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1879

CITY OF BALTIMORE: (No. 124 Callender St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frederick Pensel

(a) RESIDENCE. No. 124 Callender St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Pensel

6 DATE OF BIRTH (month, day, and year) Aug. 6" 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Retired) Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mrs. Pensel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Mrs. Alberta C. Burke (Address) 124 Callender st.

15 Filed FEB 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1920, to Feb 9, 1921, that I last saw h[illegible] alive on Feb 8, 1921, and that death occurred, on the date stated above, at 1.36 A.m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation Amended.

(duration) 1 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Hammond, M. D.

Feb 9, 1921 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethel Md.	Feb. 12 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bel St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.50746 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50746

92

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1509 Glenwood St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James N. Cochran

(Residence in Baltimore: No. 1509 Glenwood St.; 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar 7, 1879
(Month) (Day) (Year)

7-AGE, 42 yrs. 11 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) 039

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Cochran

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah R. Clay

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Cochran

(Address) 1509 Glenwood

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

FEB 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 6th 1921, to Feb 9th 1921, that I saw him alive on Feb 9th 1921, and that death occurred, on the date stated above, at 10.35 pm.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 days.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. A. Tillett M. D.

2/10/21, 191... (Address) 1827 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem DATE OF BURIAL, Feb 12, 1921

20-UNDERTAKER W. J. Tuckerton ADDRESS N. Y. Pa

N.B.—Every item of information should be carefully supplied. AGE should be stated in years and months, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50747 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hos. St.: 4 + 50 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Wade

(a) RESIDENCE. No. Glenburnie Md St., Ward. Glenburnie Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds.) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Elizabeth Wade.

6 DATE OF BIRTH (month, day, and year) Feb 2-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Wade

(Address) 230 N Carey

15 Filed FEB 10 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1921, to Feb. 9th, 1921, that I last saw him alive on Feb. 9th, 1921, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus, arteriosclerosis, nephritis,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia, edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analysis, Blood Sugar

(Signed) Wm Francis Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Feb. 1921
20 UNDERTAKER W. J. Tuckwell Son	ADDRESS N. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50748 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 120

CITY OF BALTIMORE, (No. 1648 Pennsylvania Ave. St.; 14 WARD)

2-FULL NAME Lenore Frances Bassett

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1648 Penna Ave, St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec 31, 1863 (Month) (Day) (Year)

7-AGE, 57 yrs. 1 mos. 10 ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Notion Store

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob M Bassett

11-BIRTHPLACE OF FATHER (State or Country), Bethlehem Pa

12-MAIDEN NAME OF MOTHER, Mary J France

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mollie E Bassett

(Address) 1648 Penna Ave

15-

Filed ....., 191.... ROBERT I. GAITHER, Registrar.

FEB 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10th, 1921
2nd (Month) 10 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 6th 1921, to Feb 6th 1921, that I saw him alive on Feb 10th 1921, and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Chronic nephritis

(Duration) about 10 yrs. mos. ds.

(Signed) J. Lowndes Maxwell M. D.

....., 191... (Address) 12 West North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Feb 12, 1921
20-UNDERTAKER	ADDRESS
J. P. Gaudenzi Sons	N & Pa

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50749 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50749

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Friendsbury ST.; 15 WARD) 40

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie V. Reese

(Residence in Baltimore: No. 1702 Friendsbury St.; 72 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 7 (Day), 1848 (Year)

7-AGE, 72 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Thomas

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Evans

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Reese

(Address) 2542 N. Baltimore

15- Filed FEB 10 1921, 191..... Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

N. B. Every item of information should be carefully supplied. Accurate answers to items 8 and 9 are very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 10th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 1st 1921, to Feby 10th 1921, that I saw her alive on Feby 8th 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

About 2 (Duration) yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs.....mos.....ds.

(Signed) C. M. Duvall M. D.

Feb 10 1921 (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, National Cem — DATE OF BURIAL, Feb 12, 1921

20-UNDERTAKER Wm J Tickner & Son — ADDRESS N Y Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

050750 HEALTH DEPARTMENT—CITY OF BALTIMORE 050750.

CERTIFICATE OF DEATH.

REGISTERED NO. 5 - 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 East ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lovitte

(a) RESIDENCE. No. 530 East ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	/	/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Midwife 68

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) live in Balt 50 years Md

PARENTS

10 NAME OF FATHER Geo. Flemings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Melia Woodson (Address) 530 East St

15 Filed FEB 11 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Feb 8, 1921, that I last saw h alive on Feb 7, 1921, and that death occurred, on the date stated above, at 12 am m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

Dr Edwards (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) / (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) Edward Fisher, M. D.

2-9, 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 11 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland

Should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated it may be properly classified. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50751 HEALTH DEPARTMENT—CITY OF BALTIMORE D50751

CERTIFICATE OF DEATH. + 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Henrietta Caroline Selden

(a) RESIDENCE. No. Washington, D.C. ST.. WARD. Washington D.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht.	widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Widowed

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mr R. Lee Marshall

(Address) 9 Chase St

15 FILED FEB 11 1921 ROBERT P. BEAUTER Burial Permit (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1920. to Feb. 10, 1921.

that I last saw her alive on Feb. 10, 1921.

and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Wall Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 25, 1921.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Walter H. M. D.

. 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	2-11 1921
20 UNDERTAKER Henry W. Jenkins & Son Co	ADDRESS Orchard Ave Catonsville Md

CAUSE should be stated EXACTLY. PHYSICIANS should state OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50752

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 N. Eutaw St.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Connor

(a) RESIDENCE. No. 748 N. Eutaw ST., 11 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel O'Connor

6 DATE OF BIRTH (month, day, and year) Sept 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Alex McHardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Daniel O'Connor

(Address) 748 N. Eutaw St

15 Filed FEB 11 1921 19... Registered

Burial Permit Issued

N. B.—WHITE PAPER, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1920, to Feb. 9, 1921, that I last saw h[illegible] alive on Feb 9, 1921, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green M. D.

2-10, 1921 (Address) 120½ Risgate St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb 12 1921
20 UNDERTAKER Henry W. Jenkins & Son	ADDRESS South Mitchell St

D50753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50753

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1013 Whitecourt St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sherman S. Morris

(Residence in Baltimore: No. 1013 Whitecourt Sr. St.; yrs., 9 mos. ds.)

WRITE plainly. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in non-technical terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	colored	Single

6-DATE OF BIRTH, July (Month) 16 (Day), 1920 (Year)

7-AGE, ...yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Laurence Jones

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Bertha Morris

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Morris

(Address) 1013 Whitecourt St.

15-FEB 11 1921 ROBT. J. KRAUTER
Filed....., 19..... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Mother's history of tuberculosis, W. cut of fetus sticky

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Kenney (Coroner.) M. D.

Feb. 10, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb. 11, 1921
20-UNDERTAKER John H. Toadvine	ADDRESS 143 Ostend St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50754

137

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Mills

(a) RESIDENCE. No. 576 Oxford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of John Mills.

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) 576 Oxford Street

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Bertha Barry.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) John Mills 576 Oxford St.

15 Filed FEB 11 1921 19 ROBERT E. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10 1921

17 I HEREBY CERTIFY, That I attended deceased from February 3rd, 1921, to February 10th, 1921, that I last saw her alive on February 10th, 1921, and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Peritonitis (Puerperal)

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of February 3rd

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

Feb 12, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Feb. 13 1921
20 UNDERTAKER	ADDRESS
John H. Toadvine	Catonsville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state exactly. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14612 7.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50755

1-PLACE OF DEATH

91 D50755

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susan H. Armor.

(a) RESIDENCE. No. 1501 N. Bond St. Balto ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of: Charles G. Armor

6 DATE OF BIRTH (month, day, and year): Aug. 8th, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co.

PARENTS

10 NAME OF FATHER: Nicholas McCubbin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan De Moss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: [illegible] (Address): Charles G. Armor 1501 N. Bond St.

15 Filed FEB 11 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1921, to Feb. 9, 1921, that I last saw her alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Edward C. Dobrodsky M. D.

2-10, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Cemetery-Upper Falls

DATE OF BURIAL: Feb-12-1921

20 UNDERTAKER: William Cook.

ADDRESS: 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Marie L Beyerlein

Spec.—6-3-19—H. P. Co.—1000 Bks.

1050756

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050756

CERTIFICATE OF DEATH.

REGISTERED NO. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13 Brookland Ave ST.: 21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Lillie Beyerlein

(a) RESIDENCE. No. 13 Brookland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Beyerlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen Dieffenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lillie Beyerlein
(Address) 13 Brookland Ave

15 Filed FEB 11 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 9, 1924, that I last saw he alive on Feb 9, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Probably a Basal Meningitis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tonsillitis + Rheumatism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Clara Jones, M. D.

2/10, 1924 (Address) 4706 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Feb 12 1924

20 UNDERTAKER ADDRESS
Wm Cook 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1050757 — 1050757 — 18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 624 Wyanoke Ave (Ward) 9

2-FULL NAME Ella Lee Henry

(a) RESIDENCE. No. 624 Wyanoke Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Henry

6 DATE OF BIRTH (month, day, and year): May 1/1866

7 AGE — Years: 54 — Months: 8 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bristol Penn

PARENTS

10 NAME OF FATHER: Wm A Ackerly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Minnie E McBride

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Coleman

(Address) 624 Wyanoke Ave

15 Filed FEB 11 1921 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 9, 1921, that I last saw her alive on Feb 9, 1921, and that death occurred, on the date stated above, at 7.35 a.m.

The CAUSE OF DEATH* was as follows:

Erysipelas.

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Indefinite Erysipelas

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester Md	Feb 14 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Mat[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement, of OCCUPATION is very important. See instructions on back of certificates.

Dorothy Rumney.

D50758 HEALTH DEPARTMENT—CITY OF BALTIMORE D50758

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1004 n wood ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Rumney.

(Residence in Baltimore: No. 1004 n wood St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col.	Single

6-DATE OF BIRTH, ..., (Month) ..., (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
12 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): School Girl Dead

9-BIRTHPLACE, (State or Country): Live in Balt 7 years Pa

PARENTS.

10-NAME OF FATHER, Allen Rumney

11-BIRTHPLACE OF FATHER (State or Country), D C

12-MAIDEN NAME OF MOTHER R L Miller

13-BIRTHPLACE OF MOTHER (State or Country), Norrie Town Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Ewing

(Address) 1004 W Hoff St

15- FEB 11 1921 ROBERT P. BRUTER Registrar

Filed ..... 191.... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

2-10-21, 101 1 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Norrie Town Pa	Feb 14, 1921
20-UNDERTAKER	ADDRESS
Wm R S Elliott	1726 Eckland St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50759 D50759 91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3114 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elva Burns

(Residence in Baltimore: No. 3114 Dillon St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Feby 11, 1919
(Month) (Day) (Year)

7-AGE, 2 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James E Burns

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elva Storey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Burns

(Address) 3114 Dillon

15- Filed FEB 11 1921 ROBERT P. KRAUTER Clerk Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 10, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 10 1921, that I saw h[im] alive on Feb 9 191..., and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....

.....

..... (Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Toxaemia

..... (Duration) yrs. mos. 1 ds.

(Signed) W. L. Burke M. D.

Feb. 10, 1921. (Address) 3042 Hudson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Feby 11, 1921

20-UNDERTAKER Robt E Stewart Sr — ADDRESS 1422 N Bway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50760

CERTIFICATE OF DEATH.

-40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fairfield - Frederick Road 75 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav. adolph Schlens.

(a) RESIDENCE. NO. Frederick Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE~~ of Henrietta Wilkins Schlens

6 DATE OF BIRTH (month, day, and year) Jan 26 - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. Williams

(b) General nature of industry, business, or establishment in which employed (or employer) Wilkins Co.

(c) Name of employer Hair Manf.

9 BIRTHPLACE (city or town) (State or country) Bremen Germany.

PARENTS

10 NAME OF FATHER Johann Ludwig Schlens

11 BIRTHPLACE OF FATHER (city or town) Bremen (State or country) Germany

12 MAIDEN NAME OF MOTHER Katrina Norman

13 BIRTHPLACE OF MOTHER (city or town) Bremen (State or country) Germany.

14 Informant Mrs. Ernst Endre (Address) Frederick Road.

15 Filed FEB 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Feb 10, 1921, that I last saw h~~im~~ alive on Feb 9, 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr Chas Deegen, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	2-12 1921
20 UNDERTAKER Stevens W. Perkins & Sons Co	ADDRESS McCulloh Orchard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 50761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Eutaw Heights Ave ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Rob Baker

(a) RESIDENCE. NO. 3 Eutaw Heights ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Geo. D. Baker

6 DATE OF BIRTH (month, day, and year) Sept 27-81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Rob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. D. Baker

(Address) 3 Eutaw Heights Av

15 Filed FEB 11 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 9th 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20 1920, to Feb. 9 1921, that I last saw her alive on Feb. 9 1921, and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) uraemia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Edward Novak, M. D.

, 19 (Address) 871 N. Pat. Pk. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem,	Feby 12 1921
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

D 050762 HEALTH DEPARTMENT—CITY OF BALTIMORE D 050762

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital St. 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Seidel

(Residence in Baltimore: No. 315 S. 2nd St, St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, March 11, 1907
(Month) (Day) (Year)

7-AGE 13 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrical Jointer
(b) General nature of industry, business, or establishment in which employed (or employer): Bell

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, Jacob Seidel

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Hattie German

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Seidel

(Address) 315 S. Second St.

15- Filed FEB 11 1921, 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Electric Shock

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

2-9-1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Prospect Hill Cem	Feb 11, 1921
20-UNDERTAKER	ADDRESS
Lilly & Fiske	403 S. Moffett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A50763 HEALTH DEPARTMENT—CITY OF BALTIMORE A50763

CERTIFICATE OF DEATH

1-PLACE OF DEATH Marchbank REGISTERED No. C 28 9 1

CITY OF BALTIMORE (No. 1139 Homestead St ST.: WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth C. Marchbank

(Residence in Baltimore: No. 1139 Homestead St.: 11 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Jan 11 (Month) 1857 (Day), 1 (Year)

7-AGE: 71 yrs. — mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House duties
(b) General nature of industry, business, or establishment in which employed (or employer): ..... D

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: George Winter

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Marie Beaushotte

13-BIRTHPLACE OF MOTHER (State or country): France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daughter Mrs Harryman

(Address) 1139 Homestead St

15. Filed FEB 11 1921 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb. 9 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1920, to Feb. 9 1921, that I saw h[er] alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 11.20 P.m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Ill from Nov 29-20 to Feb. 9. 21

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), H G Prentiss M. D.

Balto Feb 10, 1921 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: LOUDON PARK. DATE OF BURIAL: FEB 12 1921

20-UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Mosher ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisha Ines

(a) RESIDENCE. No. 702 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ~~mos.~~ ~~ds.~~ How long in U. S., If of foreign birth? 40 yrs. ~~mos.~~ ~~ds.~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colourd	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1828

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nightwatchman

(b) General nature of industry, business, or establishment in which employed (or employer) Md Casualty Co

(c) Name of employer Mr Eberts

9 BIRTHPLACE (city or town) (State or country) Hate Co Va

PARENTS

10 NAME OF FATHER William Ines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hate Co Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Elisha Ines (Address) 702 W Mosher St

15 FEB 11 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 — 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb. 8, 1921, that I last saw him alive on Feb. 8, 1921, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual Clinical

(Signed) William A. Harris M. D.

, 19 (Address) 1200 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 11 1921
20 UNDERTAKER	ADDRESS
John R Owens	5-38 Walbrook

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 50765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospl St.; 9 WARD)

REGISTERED No. C 175-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George D. Linick

(Residence in Baltimore: No. 1522 Gorsuch St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb 16, 1876
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 11 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): 078

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Linck

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Amelia Wagoner

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola V. Linck

(Address) 1522 Gorsuch Ave.

15-
Filed FEB 11 1921 191.... ROBERT B KRAUTER
Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an L. Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said L. Inquest. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Traumatism, Left Leg
2 Uremia
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. K. Powell M. D.
(Coroner.)
....., 191... (Address) 1938 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Feb 12, 1921
20-UNDERTAKER Wm Cook	ADDRESS 502 E North ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Luka Lamakin

D50766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1644 E Pratt St. 3 79 WARD) REGISTERED No. C

2-FULL NAME Luka Lamakin

(Residence in Baltimore: No. 1644 E Pratt St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 20, 1847
(Month) (Day) (Year)

7-AGE, 73 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Mencynski

(Address) 934 Bank St

15- FEB 11 1921 [illegible] Burial Permit Clerk

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest I find that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Gundry Coroner. M. D.

Feb 17, 1921. (Address) 1200 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Feb. 11, 1921

20-UNDERTAKER John H. Weber — ADDRESS 1103 Bank St

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

50767

HEALTH DEPARTMENT—CITY OF BALTIMORE

50767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2116 Vine St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude V. Landau

(Residence in Baltimore: No. 2116 Vine St St.; ...yrs., 7 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 29, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Landau

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Virginia Burk

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Landau

(Address) 2116 Vine St.

15-

Filed FEB 11 1921, 191... ROBERT P. BRAUER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1921, to Feb 10 1921, that I saw h[e] alive on Feb 9 1921, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Tuberculosis

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ...yrs. ...mos. 1 ds.

(Signed) Edward O'Malley M. D.

2/10/21, 191... (Address) 28 N Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leuton Park

DATE OF BURIAL, Feb 11, 1921

20-UNDERTAKER Harry H. Wotzke

ADDRESS 1132 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

050768 050768

CERTIFICATE OF DEATH.

REGISTERED NO. 050768

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Jayne Ave. Irvington ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Escott

(a) RESIDENCE. NO. 503 Jayne Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Escott

6 DATE OF BIRTH (month, day, and year) Feb 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER Wm Allhaus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Samuel Escott
(Address) 503 Jayne Ave.

15 Filed FEB 11 1921 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1915, to Feb 8, 1921, that I last saw h.e alive on Feb 8, 1921, and that death occurred, on the date stated above, at 11.41 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Mansfield, M. D.

, 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2-12-21 19

20 UNDERTAKER: George A. Farley — ADDRESS: Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50769

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Manko

(a) RESIDENCE. No. 2123 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of Mrs B. Manko

~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct. 24 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Manko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Blume

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. B. Manko

(Address) 2123 E. Preston St.

15 FILED FEB 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Feb 9, 1921, that I last saw him alive on Feb 9, 1921, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Primary Peritonitis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Jan 27-1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopical

(Signed) J. H. Sanner (Surgeon) M. D.

Feb 9, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Feb. 12th 1921

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1938 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050770 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050770

CERTIFICATE OF DEATH.

120-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1732 Gough St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna S Chaney

(a) RESIDENCE. NO. 1732 Gough St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H Chaney

6 DATE OF BIRTH (month, day, and year) Sept 4 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59.	10	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George H Chaney (Address) 1732 Gough St

15 Filed FEB 11 1921 ROBERT J. BRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1921

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1920, to 2/8, 1921.

that I last saw h.. alive on August 8, 1921.

and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebro sclerosis, Paralysis; 6 Mos.
Chronic diffuse nephritis

(duration) yrs. 8+ mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Heart failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptom

(Signed) Henry A Brathops M. D.

2/11 1921 (Address) Home 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Feb 11. 1921.
20 UNDERTAKER	ADDRESS
Kendall & Keppel & Son	37 S Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50771

CERTIFICATE OF DEATH.

REGISTERED NO. C 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S. Fremont Ave ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. McNaney

(Residence in Baltimore: No. 343 S. Fremont Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August (Month) 16 (Day), 1902 (Year)

7-AGE, 18 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Oyster Packer.

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John J. McNaney

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Bannweller

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John J. McNaney

(Address) 343 S. Fremont Ave.

15- Robert P. Harrison,

Filed FEB 11 1921, 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 9th (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 7th 1921, to Feb. 9th 1921, that I saw h[im] alive on Feb. 8th 1921, and that death occurred, on the date stated above, at 5th m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

Toxic Exposure

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

Aortic Insufficiency

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Herman A. Spencer M. D.

Feb. 11, 1921. (Address) 1940 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonnie Brae

DATE OF BURIAL, Feb. 12, 1921.

20-UNDERTAKER J. J. Raby & Son

ADDRESS 1318 Light St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~14612~~ D. 50772

D. 50772

CERTIFICATE OF DEATH.

152

REGISTERED NO. D. 50772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Aden

(a) RESIDENCE. No. 837 Hollins St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male.

4 COLOR OR RACE White.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE~~ of Noami (mother) Aden

6 DATE OF BIRTH (month, day, and year) Jan. 7. 21

7 AGE	~~Years~~	Months	Days	If LESS than 1 day, hrs. or min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Noami Cates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 Filed FEB 11 1921 Burial Permit [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8- 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7. 1921, to Feb 8 1921, that I last saw h.~~im~~ alive on Feb 8 1921, and that death occurred, on the date stated above, at 2.20 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Upon admission

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W D Davison, M. D.

2-8, 1921 (Address) J H H Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 10 1921, 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Robert P. Harrison,

Typ. Wm. K. WOODALL.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50773 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Municipal Tuberculosis Hospital St. 16 28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus Snyder

(a) RESIDENCE. No. 802 Dukeland st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unk. yrs. 56 mos. ds. How long in U. S., If of foreign birth? 38 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy E Snyder

6 DATE OF BIRTH (month, day, and year) Aug 28/1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Annick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Daisy E Snyder (Address) 802 Dukeland St

15 Filed FEB 11 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1921, to Feb. 11, 1921, that I last saw him alive on Feb. 10, 1921, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

2-11-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Olivet Cemt Feb 14 1921

20 UNDERTAKER — ADDRESS

Wm Cook 502 E Nath Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50774

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH Boyview Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Goff.

(a) RESIDENCE. No. 802 Fenge St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Fannie Goff.

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lather 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Boyview Hospital Balto. Md.

15 Filed FEB 11 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9. 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1920, to Feb. 9, 1921, that I last saw h[illegible] alive on Feb. 9. 1921, and that death occurred, on the date stated above, at 3.00 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (1 the (insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) N. Feldman M. D.

2/9/1921 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Feb. 12 1921
20 UNDERTAKER	ADDRESS
Samuel T. Hemsley	778 N. Bridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.50775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50775

151

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Vogel

(Residence in Baltimore: No. 817 S. Bromford Ave St.; 0 yrs., 0 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, February 9, 1921.
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 1 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Vogel

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Helen Pruchniewska

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Vogel

(Address) 817 S. Bromford Ave

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

FEB 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 10, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Feb 10, 1921, that I saw her alive on Feb 10, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity and Cerebral Hemorrhage

(Duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) David P. Greenberg M. D.

Feb 11, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem.

DATE OF BURIAL, Feb 11, 1921

20-UNDERTAKER Tilly & Zeller

ADDRESS 403 E. Monument

DEATH CERTIFICATE—THIS IS A PERMANENT RECORD
PRINT IN UNFADING INK
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.50776 HEALTH DEPARTMENT--CITY OF BALTIMORE D.50776

CERTIFICATE OF DEATH

10-091

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. St. Frances Convent ST. 10 WARD) Fourth & Chase sts.

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sidonia Collins

(Residence in Baltimore: No. St. Frances' Convent E. Chase St. — St. 85 yrs. 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Colored	Single

6 DATE OF BIRTH August 13 (Month), 13 (Day), 1836 (Year)

7 AGE 85 yrs. 5 mos. 26 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse 070
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: George Collens

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Collens

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother Mary Francis

(Address) St. Frances Convent

15. FEB 11 1921 Robert P. Harrison, (Burial Permit Clerk.) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February (Month) Ninth (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb 9, 1921, that I saw h[illegible] alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Influenza (probably)
Primary - Direct Cause
Broncho - pneumonia

(Duration) ..... yrs. ..... mos. 5 days

Contributory (SECONDARY) probably Influenza

(Duration) 2 yrs. — mos. — ds.

(Signed), Walter B Platt M. D.

Feb 11, 1921 (Address) 802 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death 2 — 3 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Mrs N. J. Keyers 104 W. Lanvale St

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: Feb. 12, 1921

20 UNDERTAKER: Feby B. Pye — ADDRESS: 102 E. Mulberry St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD

D. 50777 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found Dear 3 REGISTERED NO. C 184

CITY OF BALTIMORE (No. 2074 Gilmor ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Rev. 6035

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White Determined

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, unknown (Month), 1 (Day), ... (Year)

7-AGE, New Born yrs. mos. ds.

If LESS than 1 day, 1/2 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- FEB 11 1921 Robert P. Harrison, Registrar.
Burial Permit Clerk. ....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas - undoubtedly self administered. Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coroner's

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W Preston M. D. (Coroner)

Feb 10, 1921 (Address) 700 C Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ... 19....

20-UNDERTAKER Commissioner Health. Per. Wm. E. WOODALL

ADDRESS 2/11/21

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50778

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330. S. Collington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline A. Dembek.

(a) RESIDENCE. No. 330. S. Collington., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29-20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank. Dembek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia. Butka Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Julia A Dembek
(Address) 330 S Collington

15 Filed FEB 11 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Ja 10, 19 21, to Ja 11, 19 21, that I last saw h. alive on Ja 11, 19 21, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Walsh M. D.

(Address) 22 n Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 2/13 1921

20 UNDERTAKER Wm Galloway — ADDRESS 1618 Eo

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Beck

D.50779 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50779

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH German Aged Home REGISTERED NO.

CITY OF BALTIMORE: (No. Lake Ave Grayson ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina Beck

(a) RESIDENCE. NO. German Aged Home. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Beck

6 DATE OF BIRTH (month, day, and year) Jan 10 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Tenderlick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Doctor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant German Aged Home Records

(Address) Lake Ave Grayson Sts

15 Filed FEB 11 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 19 21, to Feb 12, 19 21, that I last saw h alive on Feb 12, 19 21, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy 2

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 13 19 21
20 UNDERTAKER Chas B. Cook	ADDRESS 1003 E Balto St

FEB 11 1921

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50780 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50780

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Myrtle Av St. 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorothy May Eichhorn

(a) RESIDENCE. No. 605 Myrtle Av St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? 7 yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER Fred Eichhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Fred Eichhorn (Address) 605 Myrtle St

15 Filed FEB 12 1921, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb 9th 1921, that I last saw h— alive on Feb 9th 1921, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Strain, M. D.

2/11, 1921 (Address) 1227 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 12 1921
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	Govans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Blks.

D.50781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 E Balto ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lavinia Fremont Kane

(Residence in Baltimore: No. 1026 E. Balto St.; 80 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov 27, 1837
(Month) (Day) (Year)

7-AGE, 83 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Chestertown Md

PARENTS.

10-NAME OF FATHER, Wm D Fremont

11-BIRTHPLACE OF FATHER (State or Country) Chestertown Md

12-MAIDEN NAME OF MOTHER Araminta Arthur

13-BIRTHPLACE OF MOTHER (State or Country) Chestertown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas G. Kane

(Address) 1301 Mass Ave N.W.

15-

Filed FEB 12 1921, 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 1921, to Feb. 10 1921, that I saw her alive on 11 9 1921, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Paralysis

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. G. Kane M. D.

Feb. 11, 1921. (Address) 1301 N. Mass. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Feby. 12, 1921

20-UNDERTAKER Robt J Turner Jr — ADDRESS 1442 N Broadway

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D.50782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50782

CERTIFICATE OF DEATH.

18

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Woodbourne av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Lester Enson

(Residence in Baltimore: No. 500 Woodbourne Ave St.; ....yrs., ...mos. 12 ds.)

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 11, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Wm Leslie Enson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Eliz Snyder

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L Enson

(Address) 500 Woodbourne ave

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

FEB 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to Feb 11 1921, that I saw h~~im~~ alive on Feb 11 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebritis

..... (Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo T Keating M. D.

Feb 12, 1921. (Address) 5835 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Emanuel Cemetery Glenn — DATE OF BURIAL, Feb 13, 1921

20-UNDERTAKER Wm L Brooks — ADDRESS Upperco Md

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50783 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50783

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Koch

(a) RESIDENCE. No. ~~1212 Iceland Ave.~~ 607 Biran st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 15th 1857 ~~1853~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chimney sweep

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andy Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Fifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records,

(Address) New City Hospital.

15 Filed FEB 12 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 16, 1920. to February 10 1921.

that I last saw him alive on February 9, 1921.

and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pharynx.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic Section

(Signed) P. H. Eckman, M. D.

2/10/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Feb 14th 1921
20 UNDERTAKER	ADDRESS
E. Eckman & Son	1039 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.50784 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50784

CERTIFICATE OF DEATH.

REGISTERED NO. 15-79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1371 N Calhoun St.; 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Long

(a) RESIDENCE. No. 1371 N Calhoun St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Long

6 DATE OF BIRTH (month, day, and year) Aug 29, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer Henry H Meyer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gordner H Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poolesville Md.

12 MAIDEN NAME OF MOTHER Laura E. G. Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Laura E. G. Long
(Address) 1371 N Calhoun

15 Filed Robert P. Harrison, Registrar

FEB 12 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1920, to Feb 9, 1921, that I last saw h— alive on Feb 8, 1921, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. H. Wright, M. D.

(Address) 1209 Presbman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Feb 13 1921

20 UNDERTAKER John H Toadvine — ADDRESS 142 Mitchell St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50785 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D.50785

CERTIFICATE OF DEATH. 36

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgie Foster.

(a) RESIDENCE. No. 804 So. Sharpe St. City ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Pinder (Father) Ethel Foster (Mother)

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	25	

8 OCCUPATION OF DEDUCED

(a) Trade, profession or particular kind of work Child. Ord

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Pinder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ? Md.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Jo. Hosp. records

15 Filed ... 19 ... Registrar

FEB 12 1921 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1921, to Feb. 11, 1921, that I last saw her alive on Feb. 11, 1921, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Rickets

Unknown (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Atalectasis

Unknown (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray Examinations

(Signed) James C. Foph, M. D.

Feb 14, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 13 1921
20 UNDERTAKER	ADDRESS
John H. Toadvine	1423 Eutaw St

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50786 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50786

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 919 Argyle Ave ST.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Dixon

(Residence in Baltimore: No. 919 Argyle Ave St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, November (Month) (Day), 1806 (Year)

7-AGE, 115 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Retired Seamstress)

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Brown

(Address) 919 Argyle Ave

15-

Filed ....., 191.... Robert F. Harrison,
Registrar.

Burial Permit Clerk.

FEB 12 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of Thorax

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb. 9 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hearts Island, Md — DATE OF BURIAL, Feb 12 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 142 Mill St

Spec.—8-24-14—M. & T.—2000 Blks.

D.50787 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50787

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Harlem av ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Heck

(Residence in Baltimore: No. 830 Harlem av. St.; 63 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

USE PEN AND INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 11 (Day) 1858 (Year)

7-AGE, 80 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Geo. Heck

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louise Heck

(Address) 830 Harlem

15-

FEB 16 1921

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 10. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12- 1920, to Feb. 10- 1921, that I saw h.i alive on Feb. 10- 1921, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Left Hemiplegia

about 10 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diabetes Granular Kidneys 4 or 5 years

(Duration) yrs. mos. ds.

(Signed) Carlton M Look M. D.

Feb. 11-, 1921 (Address) 1107 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem.

DATE OF BURIAL, Feb. 14, 1921.

20-UNDERTAKER W M Routson

ADDRESS 230 N Green

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50788 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50788

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jefferson

(a) RESIDENCE. No. 1807 Maryland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nancy Jefferson (mother)

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 28. Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Reamer - Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Sam Jefferson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Nancy Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: J. H. Hosp. records
(Address)

15 Filed FEB 12 1921, 19 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1921, to Feb. 10, 1921, that I last saw him alive on Feb. 10, 1921, and that death occurred, on the date stated above, at 1:25 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary): Lues, aortic aortitis, aortic insuff.

years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry M. Thomas Jr. M. D.

2-16, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 13 1921

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 1300 Division

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50789

CERTIFICATE OF DEATH.

30

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 719 W. North ave ST.; 14 WARD)

2-FULL NAME Effie May Meyer

(a) RESIDENCE. No. 719 W North ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
(or) WIFE of Richard B. Meyer

6 DATE OF BIRTH (month, day, and year) May 29 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Stineman

11 BIRTHPLACE OF FATHER (city or town) Bedford Co.
(State or country) Penna

12 MAIDEN NAME OF MOTHER Susan D. Rouzer

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co
(State or country) Maryland

14 Informant Mrs Minnie Wegefarth
(Address) 2031 Eutaw Place

15 Filed FEB 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1921, to Feb 10, 1921, that I last saw her alive on Feb 9th, 1921, and that death occurred, on the date stated above, at 12-30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Meninges.

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles Bagley, Jr. M. D.

19 (Address) Latrobe Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Feby 12 1921

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50790

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Linden Ave.. ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moritz B. Heller,

(a) RESIDENCE. NO. 2408 Linden Ave., ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Heller

6 DATE OF BIRTH (month, day, and year) Dec. 22nd. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired,

(b) General nature of industry, business, or establishment in which employed (or employer) Bedding,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany,

PARENTS

10 NAME OF FATHER Bernard Heller,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER B. Reichel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ralph C Heller

(Address) 2408 Linden Ave.,

15 Filed Robert P. Harrison, Registrar

FEB 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 12th 1921

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1920, to Feb. 12, 1921, that I last saw h.. alive on Feb. 11, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix
(Hepatic Flexure).

about (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray.

(Signed) Julius Friedenwald M. D.

. 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew	Feb 14/21
20 UNDERTAKER	ADDRESS
Wm. D. Loudheim	1184 W. Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50791

CERTIFICATE OF DEATH.

47

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Addison alley ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Henson

(Residence in Baltimore: No. 526 Addison alley St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Not Known ....., 1863
(Month) (Day) (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Fossett

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Scott

(Address) 527 E. Chase

15- Robert P. Harrison,

Filed ....., 191.....

FEB 12 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921. to Feb 10 1921, that I saw h[illegible] alive on Feb 7 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows: Acute Valvular heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Coleman M. D.

Feb 16, 1921 (Address) 2039 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Feb 13th 1921

20-UNDERTAKER A. Jones

ADDRESS 207 S. Stricker St

N.B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D.50792 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50792

CERTIFICATE OF DEATH.

REGISTERED No. C 152

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 S Ellwood Ave ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Haines

(Residence in Baltimore: No. 718 S Ellwood Ave St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 13, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 30 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Mary Haines

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Haines

(Address) 718 S Ellwood Av.

15-

Filed ....., 191....

Robert P. Harrison, Registrar.

FEB 12 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Feb 14, 1921 (Coroner) 700 Eutaw St
(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, Feb 12, 1921

20-UNDERTAKER Mrs C. Miller

ADDRESS 2334 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH FADING INK—USE PEN

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50793

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50793

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Women Home (ST.) 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Basford

(a) RESIDENCE. NO. 1400 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec. 10 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: Henry B Basford

11 BIRTHPLACE OF FATHER (city or town) (State or country): A A C Md

12 MAIDEN NAME OF MOTHER: Margaret Clagett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A A Co. Md

14 Informant (Address): Ella F Jones Matron

15 Filed 19 Robert F. Harrison, Registrar

FEB 12 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1921, to Feb 11, 1921, that I last saw h alive on Feb 11, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Senile Acdema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Feb. 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis A. A. Co Maryland	Feb. 13, 1921

20 UNDERTAKER: George J Smith

ADDRESS: 1000 W Fayette St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.50794 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Mary Wilson

(Residence in Baltimore: No. Sudbrs P. O. Md. St.; ....yrs., 6 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	S

6-DATE OF BIRTH, August (Month) 3 (Day), 1864 (Year)

7-AGE, 57 yrs. 6 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... H.W. for
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Calvert County Md

PARENTS.

10-NAME OF FATHER, Nathaniel D Wilson

11-BIRTHPLACE OF FATHER (State or Country), Calvert County

12-MAIDEN NAME OF MOTHER Mary Semmenelle

13-BIRTHPLACE OF MOTHER (State or Country), Calvert County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs T. M. Tongue

(Address) Prince Frederick Md

15-

Filed.....Robert P. Harrison.....
Registrar.

FEB 12 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Feb 12 1921, that I saw h[illegible] alive on Feb 12 1921, and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Frank D Worthington M. D.

Feb 12, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Middleham Chapel Calvert Co Md	Feb 13, 1921
20-UNDERTAKER Henry Hankins Sons	ADDRESS Orchard & McCulloh St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50795

HEALTH DEPARTMENT—CITY OF BALTIMORE

W 50795
34

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2091 W. Luzerne ave. St.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdaline Stair

(a) RESIDENCE. No. 2091 W. Luzerne ave St., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of .
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-18.97

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 067

(b) General nature of industry, business, or establishment in which employed (or employer) Hat. Dept.

(c) Name of employer Store

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John Stair

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Flaherty

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Eliz. S. Stair
(Address) 2091 W. Luzerne Av

15 [illegible] FEB 13 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to Feby 9, 1921, that I last saw her alive on Feby 9, 1921, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney,

3 yrs. ago left Kidney removed Dr. [illegible]

Duration: yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

Duration: yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. McKinney, M. D.

, 19 (Address) 6 E. Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 2-12-1921

20 UNDERTAKER J. J. Moan

ADDRESS 30 E. Baltimore

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50796

+ 176

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvalin Reese

(a) RESIDENCE. NO. Westminster, Md. ST., ... WARD. Westminster Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 5 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs A. Reese

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown & me

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown & me

12 MAIDEN NAME OF MOTHER Unknown & me

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Harvey Bankard

(Address) Westminster Md

15 Filed FEB 13 1921 ROBERT B. HEUISLER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1921, to Feb 12, 1921, that I last saw him alive on Feb. 12th, 1921, and that death occurred, on the date stated above, at 10:48 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate.

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 9th 1921

Was there an autopsy? No.

What test confirmed diagnosis? Examination & operation

(Signed) George L. Wiesig, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md Cem	Feb. 14th 1921
20 UNDERTAKER	**ADDRESS**
H B Bankard & Son	Westminster

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. 176

CITY OF BALTIMORE: (No. University Hospital ST.; ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Chenoweth

(a) RESIDENCE. No. Towsontown, Md ST., WARD. Towsontown Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 89 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Chenoweth

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Chenoweth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles Hess
(Address) Baldwin Md

FEB 13 1921 ROBERT E KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1921, to Feb. 12, 1921, that I last saw him alive on Feb. 12, 1921, and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:

Fracture neck of left femur.
Operation

(duration) yrs. mos. 90 ds.

CONTRIBUTORY (Secondary) Acute anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Dec. 2, 1920. Feb. 12, 1921.

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) W. Edwards, M. D.

3/2 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestnut Grove Church Lane	Feb 15 1921

20 UNDERTAKER	ADDRESS
E. J. Kurtz & Son	Garrett Road Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651. First ST.) (Westport 25. WARD)

REGISTERED No. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Punko

(a) RESIDENCE. No. 651. First ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mike Punko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fedosa Kusko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mike Punko
(Address) 651. First St. West Pat Md

15 Filed FEB 13 1921 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Feb 12, 1921,
that I last saw h[illegible] alive on Feb. 10, 1921,
and that death occurred, on the date stated above, at 10 30 a m.
The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2-12-1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb. 14 1921
20 UNDERTAKER	ADDRESS
John Greblinckas	425. S. Pace St.

BURIAL PERMIT AND CERTIFICATE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050799

HEALTH DEPARTMENT—CITY OF BALTIMORE

050799

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Sapp ST.: [illegible] WARD) 5 28

2-FULL NAME Mary Armstrong

(a) RESIDENCE. No. 503 Sapp ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver armstrong

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore Md. Balti.

PARENTS

10 NAME OF FATHER Robt. Ackwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti Md

12 MAIDEN NAME OF MOTHER Jane Squirrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md

14 Informant Gilli Waters
(Address) 1015 W. Lanvbury St.

15 Filed FEB 13 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1921, to Feb 10, 1921, that I last saw h[illegible] alive on Feb 10, 1921, and that death occurred, on the date stated above, at 11-15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

2-11, 1921 (Address) 120½ Eisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 13, 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 1050800

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050800

CERTIFICATE OF DEATH.

170

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hortense Barbara Cooper—

(Residence in Baltimore: No. 503 Osden st, St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 7 (Day), 1910. (Year)

7-AGE, 10 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Joseph Cooper

11-BIRTHPLACE OF FATHER (State or Country), Balto County

12-MAIDEN NAME OF MOTHER Ira Tinsley

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Cooper

(Address) 503 Osden st

15-

Filed FEB 13 1921 (By) ROBERT P. KRAUTER Registrar.

Burial Permit Issued

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~or inquiry~~) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: over

Gun Bullet wound of Chest Fired from Pistol in hands of John Richardson

(Duration) yrs. a few hours

CONTRIBUTORY (Secondary) as above

(Duration) yrs. mos. ds.

(Signed) W. R. Forrest M. D. (Coroner.)

2-12-, 1921 (Address) 117 W Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cmtry — DATE OF BURIAL, Feb 14, 1921

20-UNDERTAKER Mrs Chas B Jones — ADDRESS 218 N Pine st

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050801

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050801

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N. Lee St. ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Klein

(a) RESIDENCE. No. 618 N. Lee ST., 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Klein

6 DATE OF BIRTH (month, day, and year) June 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Septon Stove

(c) Name of employer Foundry

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Nabum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. W. Klein

(Address) 1627 E. 25th St

15 Filed FEB 13 1921 ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 12, 1921, that I last saw h[illegible] alive on Feb 11, 1921, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. Hammerbacher, M. D.

2/12/1921 (Address) 836 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 14 1921
20 UNDERTAKER	ADDRESS
Jos Feerdens Son	2078 Pac

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050802

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050802

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 Eastern Ave ST. 2 WARD)

2-FULL NAME John Haduch

(a) RESIDENCE. (No.) 918 Eastern Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. ds. How long in U. S., if of foreign birth? 28 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Maryjana Haduch

6 DATE OF BIRTH (month, day, and year) Jun 24 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Furniture

(c) Name of employer Mr Galacia Mollenauer

9 BIRTHPLACE (city or town) ..... (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Haduch

11 BIRTHPLACE OF FATHER (city or town) Galacia (State or country) Poland

12 MAIDEN NAME OF MOTHER Maryjana Petrzenuck

13 BIRTHPLACE OF MOTHER (city or town) Galacia (State or country) Poland

14 Informant Mary Jana Haduch

(Address) 918 Eastern Ave

15 FEB 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Feb 10, 1921, that I last saw h[illegible] alive on Feb 9, 1921, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. E. Ricard M. D.

2/11/21 (Address) 3100 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 14 1921

20 UNDERTAKER ..... ADDRESS

John M Weber 1803 Bank St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE WITH UNFADING INK—THIS IS

Spec.—6-9-19—H. P. Co.—1000 Bks.

2050803 HEALTH DEPARTMENT—CITY OF BALTIMORE 2050803

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S Bradford ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Bremer

(a) RESIDENCE. No. 503 S Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Bremer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wiktorya Zamerska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wiktorya Bremer

(Address) 503 S Bradford

15 FEB 13 1921 ROBERT B. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1921 to Feb 11 1921 that I last saw h[illegible] alive on Feb 11 1921 and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Evidence

(Signed) J Frost Burgess M. D.

(Address) 1500 Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Feb 13 1921

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1950804

CERTIFICATE OF DEATH.

1950804

18-041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union ave Morrill Park 25 ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Edward Stewart jr

(Residence in Baltimore: No. Union ave St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, June (Month) 21 (Day), 1917 (Year)

7-AGE, 3 yrs. 4 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James E. Stewart

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Marie Luber

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Luber

(Address) Union ave Morrill Park

15-

Filed FEB 13 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 11 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from February 9 1921, to February 11 1921, that I saw h[illegible] alive on February 11 1921, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Encephalas Bronchopneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 2 ds.

(Signed) Robert E Ketach M. D.

2/13, 1921. (Address) 2157 Bellona ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill cem — DATE OF BURIAL, Feb 14 1921

20-UNDERTAKER Wm J. Tickner & Sons — ADDRESS Paca ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. AGE should be carefully supplied. Information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50805 HEALTH DEPARTMENT—CITY OF BALTIMORE D50805

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 W. 28th st ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Atkinson

(a) RESIDENCE. No. 500 W. 28th st ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Atkinson

6 DATE OF BIRTH (month, day, and year) Dec. 17 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Quarryman

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Allan Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant (Address) James H. Barnes 500 W. 28th st.

15 Filed FEB 13 1921 19 ROLL ... LINE ... Remarks: Burial Permit ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Feb 11 1921, that I last saw him alive on Feb. 11 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion

(duration) 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What confirmed diagnosis? Chemical & microscopical examination

(Signed) Vernon F. Kelly, M. D.

2/11, 1921 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb. 15 1921
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	N. & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D50806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50806

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 E. Chase ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Jones

(Residence in Baltimore: No. 1402 E. Chase st. St.; 72 yrs., 4 mos. 11 ds.)

ACE should be stated EXACTLY. PHYSICIANS should write plainly. Every item should be carefully supplied. ACE properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 1 (Day), 1828 (Year)

7-AGE, 92 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James Jones.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Gray

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Ogden

(Address) 1402 E. Chase St.

15- Filed FEB 13 1921, 191.... ROBERT B. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to Feb 12, 1921, that I saw her alive on Feb 11, 1920, and that death occurred, on the date stated above, at 12-5 P. m.

The CAUSE OF DEATH* was as follows:

Arterial sclerosis

No hemorrhage

Uncertain (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) Edwin B. Fenby M. D.

Feb 12, 1921 (Address) 1223 N. Caroline st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Friends Cemetery

DATE OF BURIAL, Feby 14 1921

20-UNDERTAKER John O. Mitchell

ADDRESS 1201 N. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

950807 HEALTH DEPARTMENT—CITY OF BALTIMORE 950807

CERTIFICATE OF DEATH. X91-020

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.....

CITY OF BALTIMORE: (No. North Broadway ST.: (WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. Henry C. Kaufman

(a) RESIDENCE. No. Relay, Md Ludslow WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? life yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna S. Kaufman

6 DATE OF BIRTH (month, day, and year) Aug 16, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry C. Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry J. Kaufman (Address) Ludslow & Pickering ave.

15 Filed FEB 13 1921 ROBERT E. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to Feb 17, 1921, that I last saw him alive on Feb 17, 1921, and that death occurred, on the date stated above, at 1 50 P m.

The CAUSE OF DEATH* was as follows:

Colon Bicillus Septicaemia

OVER

8 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 1, '21.

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Wm Noble, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 18 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1101 W. Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPA- s on back of certificates.

ation should be carefully supplied. AGE sh- TION is very important. See instructions on b-

Spec.—8-24-14—M. & T.—2000 Bks.

1050808 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 8 79

CITY OF BALTIMORE: (No. 3305 Carlisle ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hafperka

(Residence in Baltimore: No. 3305 Carlisle St.; 88 yrs., 1 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, Dec. 20, 1832
(Month) (Day) (Year)

7-AGE, 88 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Christopher Hafperka

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Gaumer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Hafperka

(Address) 3305 Carlisle ave.

15-

Filed FEB 13 1921 ..... Registrar.

CAUSE OF DEATH in plain terms. ABBREVIATIONS or CARELESSLY supplied AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby. 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 2 years ago 191..., to Feb. 11 1921, that I saw h[illegible] alive on Feb. 5 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) [illegible] M. D.

Feb. 11, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Li Park Cemetery	Feby. 14, 1921
20-UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Fayette St

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50809 HEALTH DEPARTMENT—CITY OF BALTIMORE D50809

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Cole ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Hands

(a) RESIDENCE. NO. 1710 Cole ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Oct 12, 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
26	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nicholas Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Annie Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Del

14 Informant Mabel L Sellers

(Address) 710 Ridgley

15 Filed FEB 13 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1920, to Oct 11, 1921, that I last saw her alive on Oct 11, 1921, and that death occurred, on the date stated above, at 12 10 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 11 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam Sputum

(Signed) James T Rosenberger Jr M. D.

2/12, 1921 (Address) 1729 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge, M. E. Cem	FEB 14 1921
20 UNDERTAKER Robert Boardman	ADDRESS Calhoun Hollins

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. Sarah Rosenberg

050810 HEALTH DEPARTMENT—CITY OF BALTIMORE 050810

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Rosenberg

(a) RESIDENCE. No. 2116 Fairmount ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Simon Rosenberg

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1411 E. Baltimore St

15 Filed FEB 13 1921 Robert E. Krauter Registrar

Burial Permit Olerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Feb 11, 1921, that I last saw h alive on Feb 11, 1921, and that death occurred, on the date stated above, at 12.15P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Mortondale, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	2/13 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 Galtst

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50811 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50811

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 W. Franklin ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Stein

(a) RESIDENCE. No. 1521 W. Franklin ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widowed

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE~~ of Sophia C. Stein

6 DATE OF BIRTH (month, day, and year) March 28, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work State Secretary 086

(b) General nature of industry, business, or establishment in which employed (or employer) U. O. A. Mechanics

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John K. Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Saums

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Geo W Little

(Address) 531 N Fremont Ave

15 Filed FEB 13 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2d 1920, to Feb 12th 1921, that I last saw h[illegible] alive on Feb 11th 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat

(duration) 1 yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 720 W. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Druid Ridge	Feb 14 1921
20 UNDERTAKER	ADDRESS
Geo W Little	531 N Fremont Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050812

HEALTH DEPARTMENT—CITY OF BALTIMORE

050812

CERTIFICATE OF DEATH.

84

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1343 N. Fulton Av ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter F. Frazer

(a) RESIDENCE. No. 1343 N. Fulton Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Hans Wm Frazer

11 BIRTHPLACE OF FATHER (city or town) Pittsburgh (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret P. Stapf

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Mary P. Frazer

(Address) 1343 N. Fulton Ave

15 Filed FEB 13 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11-1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1921, to Feb 11, 1921, that I last saw h~~is~~ alive on Feb 11, 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Defect in Auricular Septum.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos C. Conser M. D.

2/12, 1921 (Address) 1101 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Lorraine — DATE OF BURIAL Feb 14 1921

20 UNDERTAKER Robert S. Little — ADDRESS 531 N Fremont Ave

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050813

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050813

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry A. Wheeler

(a) RESIDENCE. No. 250 N Pine ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Wheeler

6 DATE OF BIRTH (month, day, and year) July 2 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Keeper 066

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Store Owner and Salesman.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida G. Wheeler (Wife)

(Address) 250 N. Pine Street

15 FILED FEB 13 1921 BOYD CARTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to Feb. 9, 1921, that I last saw him alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 6:25 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

operation

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Feb. 3, 1921.

Was there an autopsy?.....

What test confirmed diagnosis? Operation

(Signed) O. H. Lewis, M. D.

2/9, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Feb. 13 1921
20 UNDERTAKER Jos. M. Johnson	ADDRESS 1234 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 050814

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Heim

(Residence in Baltimore: No. Hebre w Hospital and Asylum St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1841
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Samuel Heim

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Minnie Stern

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Maurice Meyer

(Address) 111 N Charles St Balto

15-

Filed FEB 13 1921 191... [illegible]

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1920 191 , to Feb. 12 1921 191 , that I saw him alive on Feb. 12, 1921 191 , and that death occurred, on the date stated above, at 3.55 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

..... (Duration) 2 yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) H. Winternitz M. D.

2/12/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Feb. 13., 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mad ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

050815 HEALTH DEPARTMENT—CITY OF BALTIMORE 050815

CERTIFICATE OF DEATH.

104-091

1-PLACE OF DEATH Md Gen Hosp

CITY OF BALTIMORE: (No. 3019 Eutaw Ave ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary D Kellogg

(a) RESIDENCE. NO. ~~Md Gen Hosp~~ 3019 Eutaw Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Francis Dwight Kellogg

6 DATE OF BIRTH (month, day, and year) July 15 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Edward Pearstyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Streator

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Wm D Kellogg 906 N Howard St

FEB 13 1921

[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1921, to Feb. 12th, 1921, that I last saw her alive on Feb. 12th, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Hernia. Strangulated.

..... (duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

..... (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 10th

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Fred J. Bamptfield, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Greenmount	Feb. 14, 1921
20 UNDERTAKER	ADDRESS
Kendall Leppel & Co	319 S Wm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1950816 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950816

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. St.: 8 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eleanor Forsythe

(a) RESIDENCE. No. 1501 E. Lanvale St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Forsythe

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ellis Alexander. Mr. Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret A Lockwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Florence Forsyth (Address) 1744 E. North Ave

15 Filed FEB 13 1921 16 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921, to Feb. 12 1921 that I last saw her alive on Feb. 12 1921 and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows: Carcinoma bladder

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? appearance of bladder

(Signed) H. McGarrett M. D.

(Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feb 14 1921

20 UNDERTAKER	ADDRESS
H. E. Hughes	1141 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050817 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050817

CERTIFICATE OF DEATH. 63

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5302 (ST.) Reisterstown Rd (WARD)

2-FULL NAME Franklin Bentley Heelemyer

(a) RESIDENCE. NO. 5302 Reisterstown Rd ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 - 1844

7 AGE: Years 76 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Franklintown. Balto Co Md.

PARENTS

10 NAME OF FATHER: Joseph Heelemyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredk Co Md

12 MAIDEN NAME OF MOTHER: Clarisa Barbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant: Griffith Heelemyer (Address) 5302 Reisterstown Rd

15 Filed FEB 13 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany ..., 1916, to Feb 8, 1921, that I last saw h— alive on Feb 8, 1921, and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Bubonic Paralysis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Some lesion at base of brain

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas R. Hill, M. D.

, 19 (Address) Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemy — DATE OF BURIAL: Feb 14th 1921

20 UNDERTAKER: V Bertram Gore — ADDRESS: 1723 Eutaw-ville Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1 D50818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50818

CERTIFICATE OF DEATH.

REGISTERED NO. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 1/2 St. 5 Ave Highlandtown WARD)

2-FULL NAME Margaret Weis

(a) RESIDENCE. No. 109 1/2 St. 5th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Aug 1920

7 AGE — Years: — Months: 6 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William A Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester Pa

12 MAIDEN NAME OF MOTHER: Marie E Schwab

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: William A Weis

(Address): 109 1/2 S 5th St

15 Filed FEB 13 1921 19 [redacted] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/11/21

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1921, to 2/11, 1921, that I last saw h[illegible] alive on 2/10, 1921, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Intoxication

Pulmonary Edema (duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H L Mueller, M. D.

2/11, 1921 (Address) 3325 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Feb 14 1921

20 UNDERTAKER: Daniel Easton — ADDRESS 96 Lee

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050819

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 1050819

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Gross

(a) RESIDENCE. No. 620 N. Bruce st. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Gross

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Wiese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 13 1921 19 ROBERT P. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1921, to Feb. 11, 1921, that I last saw him alive on Feb. 11, 1921, and that death occurred, on the date stated above, at 10. a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

2-11-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 14 1921
20 UNDERTAKER David Earlam	ADDRESS 916 Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50820 HEALTH DEPARTMENT—CITY OF BALTIMORE D50820

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1526 n Durham ST.: 8 WARD) REGISTERED NO. 150 C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel M. Harrington

(Residence in Baltimore: No. 1526 n Durham St. 2 yrs., 4 mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Bay

6-DATE OF BIRTH, ... Feby (Month) 13 (Day), 1918 (Year)

7-AGE, 2 yrs. 11 mos. ds. — If LESS than 1 day, ...hrs. or.....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Niagara Falls N.Y.

PARENTS.

10-NAME OF FATHER, Arbut Harrington

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Edith M. Kidd

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith M. Harrington

(Address) 1526 Durham St.

15- FEB 14 1921 Filed ....., 191.... ROBERT J. KRAUTER Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb 12 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner)

2-12-, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Hill Cemetery	Feby 14, 1921
20-UNDERTAKER	ADDRESS
J. D. Cook	502 E. Fayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D50821

1-PLACE OF DEATH

REGISTERED NO. 8

CITY OF BALTIMORE: (No. 1815 Mc Henry ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter C Saffran

(a) RESIDENCE. No. 1815 Mc Henry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond A Saffran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Daisy M Fillery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Catherine C Knelle 1815 Mc Henry St

15 Filed FEB 14 1921 19 ROBERT I GAITHER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 8, 1921, to Feb 12, 1921, that I last saw h[illegible] alive on Feb 12, 1921, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pertussis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward V Cantalupo, M. D.

2/13/1921 (Address) 74 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 14 1921

20 UNDERTAKER Wm Cahoon & Sons ADDRESS Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050822

HEALTH DEPARTMENT—CITY OF BALTIMORE

050822

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 McHenry ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton J Saffran

(a) RESIDENCE. No. 1815 McHenry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) May 3/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond A Saffran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Daisy M Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Catherine E Knelle 1815 McHenry St

15 Filed FEB 14 1921 BOYLE: FRAZIER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Feb 12, 1921, that I last saw h[illegible] alive on Feb 12 1921, and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac. asthenia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Edward J Kenderdine, M. D.

2/13/1921 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 14 1921

20 UNDERTAKER Oak 502 E Nath Ave ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 050823

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Maryland Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conza Deturi

(a) RESIDENCE. No. 1806 Maryland Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter Deturi

6 DATE OF BIRTH (month, day, and year) Dec 9/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Maneca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Masden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Pietro Deturi
(Address) 1806 Maryland Ave

15 Filed FEB 14 1921 19 ROBERT E. REAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to July 13, 1921, that I last saw h.m alive on July 13, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 7 wks yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) [illegible], M. D.

July 13, 1921 (Address) 1124 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent's Cem	Feb 16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Baltimore

AGE should be stated in CATEGORY supplied. All terms should be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 1050824

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 E. 20th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Blanche Richardson

(a) RESIDENCE. No. 1022 E. 20th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daughter Geo C & Blanche Richardson

6 DATE OF BIRTH (month, day, and year) Sept 12-1878

7 AGE	42 Years	5 Months	1 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Geo. C. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Blanche Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs J. B. Richardson

(Address) 1022 E 20th St

15 Filed FEB 14 1921 ROBERT J. BRAUTIGAM Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 13 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1920, to Feby 13, 1921, that I last saw her alive on Feby 12, 1921, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

~~Acute~~ (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Sputum~~ Physical Signs

(Signed) J. W. Kaufman, M. D.

, 19 (Address) 1439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem't	Feby 15 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105825 — 91-07 — 105825

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Elm St. Centre Bay St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael John Kotchen

(a) RESIDENCE. No. 11 Elm St., Centre Bay St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) July 22/20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Centre Bay (State or country) Md

PARENTS

10 NAME OF FATHER John Kotchen

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Schorky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant John Kotchen
(Address) 11 Elm St. Centre Bay

15 Filed FEB 14 1921 MOSES E KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb 13, 1921, that I last saw h[illegible] alive on Feb 13, 1921, and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions 24 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

2/13 1921 (Address) 211 Church St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Alles	Feb. 14 1921
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec. 6-9-19 H. P. Co. 1000 Blks.

D50826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50826

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO. 37

CITY OF BALTIMORE: (No. ..... St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Brooks

(a) RESIDENCE. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 020

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bayview Hospital (Address) Baltimore City.

15 Filed FEB 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1919 to Feb. 10, 1921

that I last saw him alive on Feb. 9, 1921

and that death occurred, on the date stated above, at 4 00 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueto Infection.

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Serological

(Signed) A. McDonnell, M. D.

2/10/1921 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-14 1921
20 UNDERTAKER	ADDRESS
L. V. Brown & Son	1870 W. Fay.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

050827

HEALTH DEPARTMENT—CITY OF BALTIMORE

050827

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3517 Fairmount St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Eugene Batz

(Residence in Baltimore: No. 3517 Fairmount Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W.	

6-DATE OF BIRTH, 7/11/91 (Month) (Day) 1 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or ..1.. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Vincent Joseph Batz

11-BIRTHPLACE OF FATHER (State or Country), Baltimore County

12-MAIDEN NAME OF MOTHER Ruth Mettard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent J. Batz

(Address) 3517 Fairmount Ave

15- FEB 14 1921 Filed....., 191.... ROBERT J. KRAUTH Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7/11/21 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/4/21 191..., to 7/11/21 191..., that I saw h.. alive on 7/11/21 191..., and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Intest. Enteritis

Shortening Sickness

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) none

(Duration).....yrs.....mos.....ds.

(Signed) J. H. Norman M. D.

7/13/21, 191... (Address) 914 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Lyons Ridge	2/14/21 191...
20-UNDERTAKER	ADDRESS
Jos. T. Tunis	1441 Broadway

It may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D50828

D. 50828

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Battery Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Overton Busch

(a) RESIDENCE. No. 1219 Battery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17-1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Cornelius Busch

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Clara M Funk

13 BIRTHPLACE OF MOTHER (city or town) Fredrick
(State or country) Md

14 Informant Cornelius Busch
(Address) 1219 Battery Ave

15 FEB 14 1921 ROBERT A KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to Feb 11, 1921, that I last saw her alive on Feb 11, 1921, and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis of cavernous sinuses

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia meningitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm L Stifler, M. D.

2/12 1921 (Address) 1219 Light St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL	FEB 15 1921

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1050829 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050829

CERTIFICATE OF DEATH.

REGISTERED No. C 1564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Oswego Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Greco

(Residence in Baltimore: No. 2646 Oswego Ave ~~St.~~; 36 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day), 1855 (Year)

7-AGE.	If LESS than 1 day,
66 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Rose Greco .....

(Address) 2646 Oswego Ave

15-FEB 14 1921 ROBERT B KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) ..... 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 23 1921, to Feb. 11 1921, that I saw her alive on Feb 8, 1921, and that death occurred, on the date stated above, at 1:40A m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

.....

..... (Duration) .....yrs. .....mos. 19 ...ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... Eugene L. Persegno ..... M. D.

Feb. 11, 1921. (Address) 2314 E. Baltz St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	2/14, 1921
20-UNDERTAKER	ADDRESS
Jos. Fahey & Son	3 N Eutaw St

Issued ....., 191....

Clerk.

Physician will please write plainly, and use no abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050830 HEALTH DEPARTMENT—CITY OF BALTIMORE 050830

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 W 40 St ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Dennis

(a) RESIDENCE. No. 903 40 St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Dennis

6 DATE OF BIRTH (month, day, and year) Mar 31 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Dennis

(Address) 903 W 40 St

15 Filed ....., 19 ROBERT I. TRAUTH Registrar

FEB 14 1921 Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1918, to Feb 12, 1921, that I last saw her alive on Feb 12 1921 and that death occurred, on the date stated above, at 1045 A. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystic Lymphoma

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs

(Signed) C F Tompkins, M. D.

2-14-1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Feb 15 1921
20 UNDERTAKER	ADDRESS
Chenowith Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Rob Garrett Hosp

CITY OF BALTIMORE: (No. 22 N Carey ST.; 15 WARD) 104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Poole

(a) RESIDENCE. No. 2332 Penna Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME Elizabeth Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Poole
(Address) 2332 Penna Ave

15 Filed FEB 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 8, 1921, to Feby 12, 1921, that I last saw him alive on Feby 12, 1921, and that death occurred, on the date stated above, at 1¹⁰ P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Colitis Media (R)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. W. Clift M. D.

2/12, 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 14 1921
20 UNDERTAKER Chenoweth Son	ADDRESS Chestnut Ave

1

1950832 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 55 Spring Roe ST.: 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. McKeever

(Residence in Baltimore: No. 55 Spring Roe St.; yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W.	Married

6-DATE OF BIRTH, Dec 22, 1855
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas. A. McKeever

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Bowe

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah McKeever

(Address) 55 Spring Roe

15- FEB 14 1921 ROBERT J. BRAUER

Filed ..., 191... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. Morrissey M. D.
(Coroner.)

Feb 13, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary's Hampden	Feb 14 1921
20-UNDERTAKER	ADDRESS
Chenoweth & Son	Cheltenham

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2050833 HEALTH DEPARTMENT—CITY OF BALTIMORE 2050833

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 Stricker ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Bennett

(a) RESIDENCE. NO. 1346 Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harvey Bennett

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Has not worked for years

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Laura Brightman

(Address) 1346 Stricker St

15 Filed FEB 14 1921 ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to Feb 11, 1921, that I last saw her alive on Feb 11, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. William Fray, M. D.

2/12, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel, Md	Feb 15 1921
20 UNDERTAKER	ADDRESS
Sam'l. Pearce Sons	405 Walker

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050834 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050834

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1103 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Johnson

(a) RESIDENCE. No. 1103 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of Albert Johnson

6 DATE OF BIRTH (month, day, and year): Aug 15 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Isabella Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Albert Johnson 1103 Mosher

15 Filed FEB 14 1921 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Feb 11, 1921, that I last saw h.. alive on Feb 11, 1921, and that death occurred, on the date stated above, at 7.55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leuk M. D.

, 19 (Address) 131 S Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Feb 14 1921

20 UNDERTAKER: Jam. H. Case & Son — ADDRESS: 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—F-24-14—M. & T.—2000 Blks.

050835 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 050835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 N. Stricker St.; 15 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Pilgreman

(Residence in Baltimore: No. 1335 N. Stricker St.; 19 yrs., ... mos. [illegible] ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1902 (Year)

7-AGE, 19 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James A. Pilgreman

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Rose Hussey

13-BIRTHPLACE OF MOTHER (State or Country) MARYLAND

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Pilgreman

(Address) 1335 N. Stricker St.

15- Filed FEB 14 1921 191.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 1921, to Feb 13 1921, that I saw h[illegible] alive on Feb 13 1921, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. few ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Daughtery M. D.

Feb. 13, 1921. (Address) 1602 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb. 15, 1921

20-UNDERTAKER Sam'l. Chase & Son

ADDRESS 1400 Mosher

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

050836

HEALTH DEPARTMENT—CITY OF BALTIMORE

050836

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Pressman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B. Herth

(Residence in Baltimore: No. 3017 Pressman St. St.; 68 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, June 7, 1848 (Month) (Day) (Year)

7-AGE, 72 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Not any
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Chas. Kirschner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know -

13-BIRTHPLACE OF MOTHER (State or Country), Germany -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Gustav. Herth

(Address) 3017 Pressman St.

15-

Filed ..... 191... FEB 14 1921 ..... Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1921, to Feb. 12th 1921, that I saw her alive on Feb 12th 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Dickson M. D.

Feb 12th, 1921 (Address) 3035 West North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Feb. 15, 1921
20-UNDERTAKER	**ADDRESS**
Mr. Jas. John M. Tenfelderson	501 N. Fayette

important. See instructions on back of certificate. Unless properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050837 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050837

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Crystal Ave ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Stewart

(a) RESIDENCE. NO. 1705 Crystal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Grace E. Stewart

6 DATE OF BIRTH (month, day, and year) June 22 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mattress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles E. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs Grace E. Stewart
(Address) 1705 Crystal Ave

15 Filed FEB 14 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb 12, 1921, that I last saw him alive on Feb 12, 1921, and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ~ yrs. ~ mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) John A. Fenby M. D.

2/13 1921 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 15 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	810 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cora Lenning

Spec.—6-9-19—H. P. Co.—1000 Blks.

D50838 HEALTH DEPARTMENT—CITY OF BALTIMORE D50838

CERTIFICATE OF DEATH. 131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Cora Lenning

(a) RESIDENCE. NO. 514 S. Third St. ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis J. Lenning.

6 DATE OF BIRTH (month, day, and year) Sept. 28—1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Pa.

PARENTS

10 NAME OF FATHER Henry K. Wentz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rebecca A. Mathias

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Louis J. Lenning.

(Address) 514 S. 3rd St.

15 Filed FEB 14 1921 ROBERT F. LAUTER Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb ....., 1921 to Feb 13 , 1921, that I last saw her alive on Feb 13 , 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Cystic Ovary

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Feb 10. 21

Was there an autopsy? No

What test confirmed diagnosis? Operating

(Signed) M. L. Rodbell M. D.

, 19 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Feb. 16 1921

20 UNDERTAKER Lilly & Feiler ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

A50839 HEALTH DEPARTMENT—CITY OF BALTIMORE A50839

CERTIFICATE OF DEATH. 146

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. 3426 Mt. Pleasant ST.: 26 WARD)

2-FULL NAME Mary Schneider

(a) RESIDENCE. No. 3426 Mt Pleasant Ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed or Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 5./1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8. years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER Louis Schneider

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Emma McGuire

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant L. Schneider
(Address) 3426 Mt. Pleasant st

15 Filed FEB 14 1921, 19 ROBERT J. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Feb 12, 1921, that I last saw her alive on Feb 12, 1921, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Osteomyelitis femur
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-12-21

Was there an autopsy? No

What test confirmed diagnosis? Clinical symp. findings

(Signed) T. C. Marrs, M. D.

2-14-1921 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Feb. 15 1921

20 UNDERTAKER George J Rutter ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1 1050840 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. St.: 16 Ward) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. Spriggs

(Residence in Baltimore: No. 1010 Edmondson Ave St.; 67 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, April 10, 1853 (Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manufacturers agent
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Thomas Spriggs

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Ann Powers

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. I. F. Spriggs

(Address) 1010 Edmondson Ave

15-

FILED FEB 14 1921 ROBERT J. KRAUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1/2 hr.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Feb. 13. 1921 (Address) 3803 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1010 Edmondson Ave

Former or usual residence Same

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Feb 14 1921
20-UNDERTAKER	ADDRESS
Chas E Evans & Co	102 Watson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~450841~~ 24 ~~450841~~

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Krausenberger

(a) RESIDENCE. No. 1232 Wall Street. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1833

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	4.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address) New City Hospital.

15 FEB 14 1921 ROBERT P. KNAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 9, 1921 to February 12, 1921 that I last saw her alive on February 11, 1921 and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Face (Basal cell) unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Secondary anemia and Cachexia unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Micro. Section

(Signed) F. A. Holden, M. D.

2/12/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Feb 14 192
20 UNDERTAKER	ADDRESS
Mrs. E. E. Lamdin	648 Cherry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

950842 HEALTH DEPARTMENT--CITY OF BALTIMORE 150842

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 10 150842

CITY OF BALTIMORE (No. 2138 E. North Ave St.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Beekman Oliver Easter.

(Residence in Baltimore: No. 2138 E. North Ave St.: 1 yrs. 8 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 13 (Day), 1819. (Year)

7 AGE: 1 yrs. 8 mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George C. Easter

11 BIRTHPLACE OF FATHER (State or country): Md. (Balto.)

12 MAIDEN NAME OF MOTHER: Marie Madden

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George C. Easter

(Address) 2138 E. North Ave.

17 Filed FEB 14 1921, 191 — ROBERT A KRAUTER Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February (Month) 13 (Day), 1921. (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feby 11, 1921, to Feby 13 1921, that I saw him alive on Feby 13, 1921, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Acute intestinal infection

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) acidosis.

(Duration) yrs. mos. 1 ds.

(Signed) H. H. Arthur M. D.

Feby 13, 1921 (Address) 1426 W Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mount Carmel — DATE OF BURIAL: Feb 15, 1921

20 UNDERTAKER: David S. Keeman — ADDRESS: 32 S Broadway.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

1050843. HEALTH DEPARTMENT—CITY OF BALTIMORE 1050843

+88

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Shanklin.

(a) RESIDENCE. NO. Fullerton, Md. ST..... WARD. Fullerton Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of B. W. Shanklin (Husband) Emory Turnbull (nephew)

6 DATE OF BIRTH (month, day, and year) Dec. 25,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Baltimore Unknown Md

PARENTS

10 NAME OF FATHER Isaac Van Horn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Chalk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant J. H. Hosp. records (Address)

15 Filed FEB 14 1921 ROBERT F. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 —, 1921, to Feb. 13, 1921, that I last saw her alive on Feb. 13, 1921, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency & Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Infected wound OBW

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 31, 1921

Was there an autopsy? No.

What test confirmed diagnosis? History & Physical Examination

(Signed) F. G. Carter, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Feb. 16th 1921
20 UNDERTAKER Fred Lassahn & Son	ADDRESS Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Colloid Goitre

Calcareous degeneration

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050844

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050844

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Curtis

(a) RESIDENCE. No. York Road and McCabe Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House servant 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer E.B.McCabe

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Curtis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes Fennell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed FEB 14 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1920, to Feb. 12, 1921, that I last saw him alive on Feb. 11, 1921, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) C. S. Fahndrich, M. D.

2-12-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Laurel Cem.	Feb 14 1921
20 UNDERTAKER	ADDRESS
John H. Toadvine	142 Mt. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

4050845

HEALTH DEPARTMENT—CITY OF BALTIMORE

3750845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Oberberger St. 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child of Annie & George A Goodwin

(a) RESIDENCE. No. 324 Oberbern St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/12/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George A Goodwin

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Heusner

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) 324 Oberbern St

15 Filed FEB 14 1921 Registrar

ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/1921

17 I HEREBY CERTIFY, That I attended deceased from 2/12/1921, to 2/13/1921, that I last saw h[illegible] alive on 2/13/1921, and that death occurred, on the date stated above, at 7:30A m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W F Howell, M. D.

2/13/1921 (Address) 7640 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery Mr. Jones	Feb 14 1921
20 UNDERTAKER Mrs Chas R Jones	ADDRESS 211 N Pine St

IMPORTANT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 50846

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 E. Monument ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steward D. Taylor.

(a) RESIDENCE. No. 938 E. Monument St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Judy Taylor

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Hauling

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Life in Baltimore 60 years North Carolina

PARENTS

10 NAME OF FATHER Lochart Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Judy Taylor Anna Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant [illegible] (Address) 105 1518 E. Monument

15 Filed FEB 14 1921 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 12, 1921, that I last saw h[illegible] alive on Feb 12, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos D Finch, M. D.

2/14 1921 (Address) 938 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. [illegible] Cem

DATE OF BURIAL Feb 14 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-11—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50847 X 130 D 50847

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Brakeman

(a) RESIDENCE. No. 1032 N Wolfe St ST., WARD. South Carolina

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Institution yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) live in Baltimore 1 month
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Om Brakeman

11 BIRTHPLACE OF FATHER (city or town) S C
(State or country) S C

12 MAIDEN NAME OF MOTHER Annie Hudson

13 BIRTHPLACE OF MOTHER (city or town) S C
(State or country) S C

14 Informant Dr Hosp records
(Address)

15 Filed FEB 14 1921 ROBERT A ELLIOTT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Feb 18 1921, that I last saw her alive on Feb 13 1921, and that death occurred, on the date stated above, at 11½ a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis Disease
Myocarditis (Not Diagnosed)

(duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 2 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 26, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Brock, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Irmo S C	Feb 14 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

Burial Permit Given

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

50848 HEALTH DEPARTMENT—CITY OF BALTIMORE 50848

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Ridge

(a) RESIDENCE. No. 1505 Williams St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 1921

7 AGE — Years | — Months | 3 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm. Ridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) J. H. Hosp. records

15 FEB 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 1921 to Feb 13 1921, that I last saw her alive on Feb 13 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) W. Davison, M. D.

19 (Address) JHH Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	2/14 1921
20 UNDERTAKER	ADDRESS
S. F. Wilson & Cully	130 E. Fay.

TION is very important. See instructions on back of certificates.

D50849 HEALTH DEPARTMENT—CITY OF BALTIMORE D50849

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 9 Beach St. Curtis Bay. St.: 25 78 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burton Tierney.

(Residence in Baltimore: No. 9 Beach St. Curtis Bay. St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, October 18th. 1866, 1 (Month) (Day) (Year)

7-AGE, 54 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe fitter.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Lewis Co. W. Va.

PARENTS.

10-NAME OF FATHER. Michael B. Tierney.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary C. Hacker.

13-BIRTHPLACE OF MOTHER (State or Country), Lewis Co, W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Tierney. (brother)

(Address) Dunbar, Pa.

15- Filed FEB 14 1921 191.... ROBERT F. KRAUTER Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 11th. 1921. (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. Kennard M. D. (Coroner.)

Feb 14, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	FEB 14, 1921
20-UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

950850 HEALTH DEPARTMENT—CITY OF BALTIMORE 950850

CERTIFICATE OF DEATH.

REGISTERED NO. C 13 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 Salem ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorine A Burch

(Residence in Baltimore: No. 2511 Salem St.; 4yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July 21, 1900 (Month) (Day) (Year)

7-AGE, 20 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Christian Lang

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Myrtle Maurer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Lang

(Address) 2511 Salem St

15- FEB 14 1921 ROBERT P. KRAUTER REGISTRAR Registered.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 7 1921, to Feb 12 1921, that I saw h[illegible] alive on Feb 12 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Frank B Jewett M. D.

, 191... (Address) 2516 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contractrd, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Western Cemetery	Feb 15, 1921.
20-UNDERTAKER	ADDRESS
Josiah Boyce	1400 W North Ave

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D50851 HEALTH DEPARTMENT—CITY OF BALTIMORE D50851

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED No. C 154

CITY OF BALTIMORE (No. 7500 Foster Av ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Stalaska

(Residence in Baltimore: No. 7500 Foster Av St.; (yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stalaska

(Address) 7500 Foster Av

15-

Filed FEB 14 1921 ROBERT P. KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Wednesday find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thomas J. Mahon M. D.
(Coroner)

Feb 14, 1921 (Address) 1800 Eastern Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Feb 14, 1921

20-UNDERTAKER Wm. F. Calloway

ADDRESS 1618 Eastern Av.

Spec.—6-9-19—H. P. Co.—1000 Blks.

~~40130~~ 150852

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-09 150852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Pelepski

(a) RESIDENCE. NO. 527 S. Bond St. City ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Pelepski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Krager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Hosp records

15 Filed FEB 14 1921 [illegible] KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 8, 1921, to Feb 13, 1921, that I last saw her alive on Feb 13, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Empyema complicated by a terminal pneumonia died a pneumothorax

Empyema Rt Side (duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 2-9-21

Was there an autopsy? No

What test confirmed diagnosis? Auscultation percussion palpation. ~~and inspection~~

(Signed) H. S. Carter, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	2/14/20 19
20 UNDERTAKER William Fralkowski	ADDRESS 1619 Eaton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Whooping Cough + Bronchi Pneumonia.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050853 HEALTH DEPARTMENT—CITY OF BALTIMORE 050853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baylein Hospital REGISTERED NO. 9-08

CITY OF BALTIMORE, No. ..... St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mosbell Selby.

(a) RESIDENCE. No. 1535 W. Franklin St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Louisa Selby

6 DATE OF BIRTH (month, day, and year) Sept 26 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lobber

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do. Carroll Co. Md.

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant: Baylein Hospital (Address): Balto, Md.

15 Filed FEB 14 1921 SOLOMON H. FRAUTEN Registrar

Burial Permit 01668

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1921, to Feb. 12, 1921, that I last saw h[illegible] alive on Feb. 12, 1921 and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Artero Sclerotic Brain Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No thereof

What test confirmed diagnosis? Clinical Findings

(Signed) N. Fedonita, M. D.

2/13/1921 (Address) Bay view Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Freedom Carroll Co Md.	Feb 15 1921
20 UNDERTAKER	ADDRESS
H M Routson	2238 W North.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50854 HEALTH DEPARTMENT—CITY OF BALTIMORE D50854

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2143 Division ST. 14 WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Bethel

(Residence in Baltimore: No. 2514 Oak St. St.: 8 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 5, 1882 (Month) (Day) (Year)

7-AGE, 39 yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: cook
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. E. E. Wilson

(Address) 1925 Park Ave.

15- Filed FEB 14 1921 191 ROBERT B. BRAUER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease 1/2 hr.,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Feb 12 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Gt. Auburn

DATE OF BURIAL, Feb 14 1921

20-UNDERTAKER C. W. H. Holland

ADDRESS 1631 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Blks.

Gordon Bruning

D50855 HEALTH DEPARTMENT—CITY OF BALTIMORE D50855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Pa Ave St.; 15 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Bruning

(Residence in Baltimore: No. 2226 Penna Ave St.; .....yrs,,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	white	single

6-DATE OF BIRTH, March 8th (Month) (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
3 yrs. 11 mos. 6 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, George Bruning

11-BIRTHPLACE OF FATHER (State or Country) Balto City

12-MAIDEN NAME OF MOTHER Emma N Taylor

13-BIRTHPLACE OF MOTHER (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Bruning

(Address) 2226 Penna Ave

15- FEB 14 1921 Registered

Filed....., 191.... [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I saw h..... alive on .....191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....Diphtheria Toxemia

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Feb. 15..., 1921

20-UNDERTAKER	ADDRESS
Martin Feheley & Sons	1827 W Pra

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View. WARD) 24

REGISTERED NO. 1921 07

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Halen or Helen. HAHN

(a) RESIDENCE. No. 1038 Hanbert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Records. (Address) City Hospital, Bay View.

15 Filed FEB 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1921, to Feb. 12, 1921, that I last saw him alive on Feb. 12, 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fibrinous pericarditis.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) P. H. Herman, M. D.

Feb. 13 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross & Co	2-14 1921
20 UNDERTAKER E and B Hale	ADDRESS 1158 West

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

450857 HEALTH DEPARTMENT—CITY OF BALTIMORE 450857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Dolphin ST.: 17 WARD) 20

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia C Lemke

(Residence in Baltimore: No. 700 Dolphin St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word)
Female	White	Single

6-DATE OF BIRTH, May (Month) 7 (Day), 1847 (Year)

7-AGE, 73 yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Adolph Lemke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Minnie Herman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Kindelman

(Address) 700 Dolphin

15-

Filed ....., 191.... Registrar

FEB 14 1921 BUREAU OF VITAL STATISTICS Social Pacific

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1920 to Feb 11 1921, that I saw h[illegible] alive on Feb 10 1921, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Apoplexia Bright's Disease

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Cerebri

(Duration) yrs. mos. 2 ds.

(Signed) Jonah D Colvin M. D.

Feb 14 1921 (Address) 1516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	2-14, 1921

20-UNDERTAKER E and B Hale ADDRESS 115 E N Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050858 HEALTH DEPARTMENT—CITY OF BALTIMORE 050858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH CITY OF BALTIMORE: (No. New City Hospital ST.: 6 WARD) 175

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Cook

(a) RESIDENCE. No. 2398 N. Durham ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widower

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 5 9 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Geo Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore

14 Informant: New City Hospital Records.
(Address)

15 Filed FEB 14 1921 BOBBS & KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1921, to 2-13, 1921, that I last saw him alive on 1-12, 1921, and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

Urinary Fistula
(in perineum)
(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Genera[illegible] spirit
Cystitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.

2-13 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemtery	Feb. 16 1921
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

050859 HEALTH DEPARTMENT—CITY OF BALTIMORE 050859

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Wolfe ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hodges

(a) RESIDENCE. No. 1037 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles. Hodges

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32.	Years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Jno. Runnels.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Kerr.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles. Hodges
(Address) 1037 N. Wolfe St.

15 FEB 14 1921 BOARD OF HEALTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 12 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 2 - 7 -, 1921, to 2 - 12 -, 1921, that I last saw h~~er~~ alive on 2 - 12 -, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Indigestion 6 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

2-13, 1921 (Address) 611 - N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery.	Feb. 14 1921
20 UNDERTAKER	ADDRESS
Newton Davis	913 N. Eden St.

TION is very important. See instructions on back of certificates.

ay be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic

Spec.—6-9-19—H. P. Co.—1000 Bks.

050860 HEALTH DEPARTMENT—CITY OF BALTIMORE 050860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 Vincent St.: 19 120 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millie Johnson

(a) RESIDENCE. No. 323 Vincent St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Johnson.

6 DATE OF BIRTH (month, day, and year) Nov. 10? 1863?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) Washing & Ironing

(c) Name of employer Home.

9 BIRTHPLACE (city or town) (State or country) Howard County

PARENTS

10 NAME OF FATHER David Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard County

12 MAIDEN NAME OF MOTHER Emily.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County.

14 Informant Emma Johnson (Address) 323 Vincent alley.

15 Filed FEB 14 1921 19 ROBERT A. CHANTLER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb 11, 1921, that I last saw her alive on Feb 11, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Chronic ? +

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Obstipation (Constipation)

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

Feb 12, 1921 (Address) 1209 Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 14 1921
20 UNDERTAKER	ADDRESS
Brown & Freeland	Schroder

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1 PLACE OF DEATH 2050861

City Baltimore

County

150 STATE OF MARYLAND
CERTIFICATE OF DEATH

2050861

Registration Dist. No. 44

Village or City St Helena (No. 318 Colgate Av St. 26 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Leonard Emmet Leverton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan. 23d, 1921 (Month) (Day) (Year)

7 AGE: — yrs. — mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): St. Helena, Balto. Md.

PARENTS

10 NAME OF FATHER: Wayson C. Leverton

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Grace R. Ruhl

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wayson Leverton

(Address) St Helena

15 Filed Jan 29, 1921 G. H. McCormick M.D.

FEB 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. 29th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 23d, 1921, to Jan 29th, 1921, that I last saw him alive on Jan. 29, 1921, and that death occurred on the date stated above, at 10 A M

The CAUSE OF DEATH * was as follows:

Hydrocephalus

(Duration) yrs. mos. 6 ds.

Contributory Secondary: Convulsions

(Duration) yrs. mos. ds.

(Signed) G. H. McCormick M. D.

Jan 29, 1921 (Address) Spanish Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ...

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Louden Park — DATE OF BURIAL: Jan 30, 1921

20 UNDERTAKER: Philip Hennig — ADDRESS: Balto.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050862 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050862

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Hollins St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Cohen

(a) RESIDENCE. No. 1022 Hollins St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) ~~WIFE~~ of Anshel Cohen

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis
(Address) 1411 E Baltimore St

15 Filed FEB 14 1921 ROBERT P. TRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1921, to Feb 13, 1921, that I last saw h alive on Feb 12 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Paralysis
Endocarditis Chronic
Nephritis
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) ... M. D.

. 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Ward Rd. DATE OF BURIAL 2/14/21

20 UNDERTAKER Jake Lewis ADDRESS 1411 E Balt

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D50863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50863

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Wilhelm ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Sommer

(Residence in Baltimore: No. 1836 Wilhelm St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 15 (Month) Feb. (Day), 1856 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework (?)
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Stevens

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER ..... Sanders

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Chas. A. Sommer

(Address)..... 1836 Wilhelm St.

15- FEB 14 1921 ROBERT A KRAUTER

Filed....., 191..... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 9 1921, to Feb 12 1921, that I saw h[illegible] alive on Feb 12 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cystic Goiter

Chronic Interstitial Nephritis

(Duration) 1 yr. mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis, Pulmonary Oedema

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Robert C. Kelly Jr. M. D.

2/14/, 1921. (Address) 2151 Harlem

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb 15 1921

20-UNDERTAKER Geo. Schmatz & Bro. — ADDRESS 2101 Pratt

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D50864 HEALTH DEPARTMENT—CITY OF BALTIMORE. 28 50864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 Frederick Av ST.; 20 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola R Hull

(Residence in Baltimore: No. 2822 Frederick Av St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, July 31, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Nicholas Whitelaw

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lucy Farrell

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles G. Hull

(Address) 2822 Frederick Ave

15-FEB 14 1921 ROBERT B. CHANTER

Filed ....., 191.... Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1919, to Feb 10 1921, that I saw h[illegible] alive on Feb 9 1921, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY. Pulmonary Tuberculosis (Secondary)

(Duration) 1 yrs. 6 mos. ds.

(Signed) James F Kemp M. D.

Feb 17, 1921. (Address) 172 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb 14 1921

20-UNDERTAKER Geo. A. Schmidt & Bro — ADDRESS 2101 Fredk. Ave

Important. See instructions on back of certificate.

Brauns

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50865

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Brauns

Formerly

(a) RESIDENCE. NO. 2304 W. Fayette St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Not Known mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Brauns

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Abt 38 Years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Not Known (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Bauer

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Germany

12 MAIDEN NAME OF MOTHER Gredia Schneider

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

15 Filed FEB 14 1921 ROBERT A. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20-1917, 19..., to Feb 13th 1921, 19..., that I last saw h. alive on Feb 13th, 1921, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis - following (Acute Congestion of Lungs)

Abt (duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Mania - (Post Puerperal)

Abt (duration) 3 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Feb 13th, 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Feb 16th 19
20 UNDERTAKER	ADDRESS
Arnold Aron	1729 W Pratt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Schnitzlein

HEALTH DEPARTMENT—CITY OF BALTIMORE

L050866 L050866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Caton Ave ST.: 20 WARD) 21

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schnitzlein

(a) RESIDENCE. NO. 509 Caton Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER John Schnitzlein

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Catherine Hoch

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant John Schnitzlein (Address) 509 Caton Ave

15 Filed FEB 14 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1921, to Feb 13 1921, that I last saw her alive on Feb 13 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Convulsion

Cause not Known

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

2-14 1921 (Address) Dunbar Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Feb 16 1921
20 UNDERTAKER George A Tinley	ADDRESS Fulton Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

950867 HEALTH DEPARTMENT—CITY OF BALTIMORE 950867

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 304 W Madison ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Marsiglia

(a) RESIDENCE. No. 304 W. Madison ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) 1917-3-16

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Marsiglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sicily

12 MAIDEN NAME OF MOTHER Josephine Saia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sicily

14 Informant Joseph Marsiglia (Address) 304 W. Madison St

15 Filed FEB 14 1921 ~~BOWEN & EDMUNDS~~ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Feb. 13, 1921, that I last saw h.er alive on Feb 13, 1921, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema —
Acute Cardiac Dilatation

(duration) 0 yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Suspected Laryngeal Diphtheria (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Intubation

Did an operation precede death? Date of 2-13-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Parker M. D.

, 19 (Address) 451 E. 22nd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary Cathedral	2-14 1921
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Sons Co.	McCulloh Orchard

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Blks.

050868

HEALTH DEPARTMENT—CITY OF BALTIMORE

050868

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1036 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William W Werner

(Residence in Baltimore: No. 1036 N Gay St.; 7 yrs., 5 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, August 13, 1913 (Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William W. Werner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ada Hepler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William W. Werner

(Address) 1036 N. Gay St

15- FEB 14 1921 ROBERT P. BRAUTIGAM

Filed....., 191.....

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 26th 1921, to February 12th 1921 that I saw him alive on February 12th 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Associated with Cardiac
Hypertrophy (Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Heart Collapse with Exhaustion (Duration) ....yrs. ....mos. 3 ds.

(Signed) Amelia L Lück, M. D.

February 22 191.. (Address) 1717 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Feb. 15, 191..

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N Bond

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

2050869

HEALTH DEPARTMENT—CITY OF BALTIMORE

2050869

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 McCulloh ST. 14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. G. Spencer

(a) RESIDENCE. No. 1427 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bellman 070

(b) General nature of industry, business, or establishment in which employed (or employer) Club House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas G Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thos G. Spencer (Address) 1427 McCulloh

15 FEB 14 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Feb 12, 1921, that I last saw him alive on Feb 12, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

2/13, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St John's Frederick Md	Feb 16th 21

20 UNDERTAKER Clarence E Wright ADDRESS 1364 Mary

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

050870 HEALTH DEPARTMENT—CITY OF BALTIMORE 050870

CERTIFICATE OF DEATH.

79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 West Lexington ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Bentley Jr.

(a) RESIDENCE. No. 1814 West Lexington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wh.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1901

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William J Bentley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Elgra E Darringer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant Mrs Elgra E Bentley
(Address) 1814 West Lexington St

15 Filed FEB 14 1921 ROBERT A LEAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1921, to Feb 11, 1921, that I last saw him alive on Feb 11, 1921, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 36 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) Vernon N. Condon, M. D.

2/11, 1921 (Address) 730 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb. 15" 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Balto St

TION is very important. See instructions on back of certificates.

D. 50781 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 804 n Belnord St.; 7 WARD)

REGISTERED No. C 83

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Barbarka

(Residence in Baltimore: No. 804 n Belnord St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, ... Oct. (Month) Known (Day), 1 ..... (Year)

7-AGE, ... 54 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Stanek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Caly. Sachor

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Chelko

(Address) 504 N. Belnord Ave

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 12 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pneumonia, Flow .....

..... Tumor Gall Bladder .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct. 15, 1921
20-UNDERTAKER	ADDRESS
Edward Crook Son	1906 Orleans

Please write plainly in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Unless properly classified, delayed

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50872 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50872

CERTIFICATE OF DEATH.

91-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay St. View WARD) 15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Preelit.

(a) RESIDENCE. No. 2017 Mukeland Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records. City Hospital, Bay View

Filed FEB 14 1921, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Feb. 13, 1921, that I last saw him alive on Feb. 13, 1921, and that death occurred, on the date stated above, at 12 15 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. H. Eastman, M. D.

Feb. 13, 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Feb 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50873

152

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Md. Meil. Hosp.

CITY OF BALTIMORE: (No. ..... ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mc Gronan Jr.

(a) RESIDENCE. No. Md General Hospital ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ——

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ——

6 DATE OF BIRTH (month, day, and year): Feb. 3/1921

7 AGE: Years ..... Months ..... Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Mc Gronan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Mary Cooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Mary Gronan

(Address): Pennsylvania

15 Filed ..... 19 .....

Registrar

Burial Permit Clerk

FEB 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921, to Feb. 14 1921, that I last saw him alive on Feb. 14 1921, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atabetosis

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Fred B. Smith, M. D.

, 19 (Address) Md. Meil. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Philey, Pa.

DATE OF BURIAL: Feb 15 1921

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 E North ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50874 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50874

CERTIFICATE OF DEATH.

REGISTERED NO. 15 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4700 Garrison Boulevard ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Theresa Heine

(a) RESIDENCE. No. 4700 Garrison Boulevard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	23	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph F. Heine

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna T. Schutz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Joseph F. Heine
(Address) 4700 Garrison Boulevard

15 Filed 4 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1921

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to Feb 11, 1921, that I last saw h[illegible] alive on Feb 11, 1921, and that death occurred, on the date stated above, at 3.35 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - 2 Physicians

(Signed) Thos E. O'Neill M. D.

2/14. 1921 (Address) 827 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/15 1921
20 UNDERTAKER	ADDRESS
Henry W. Hears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.50875 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50875

CERTIFICATE OF DEATH. 64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 716 N. Fulton Ave. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Townshend

(Residence in Baltimore: No. 716 N. Fulton Ave, St.; yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, November, 1845
(Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jamish Townshend

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Eliz. Moore

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. G. C. Powell

(Address) 716 N. Fulton Ave

15- Filed Feb 15, 1921, 191.... Robert I. Harrison, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (15 minutes)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

() (Duration) yrs. mos. ds.

(Signed) J. C. J. Hemmeter M. D.
(Coroner)

Feb. 14, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place 716 N. Fulton Ave in the of death yrs. mos. 6 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence (Town) Mc Kendree Georges Co. Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mc Kendree Md.	2-16, 1921
20-UNDERTAKER	ADDRESS
H. J. Trickner & Son	North Penna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50876 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 E. Madison ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine K. Ries

(a) RESIDENCE. NO. 2004 E. Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? 55 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdinand Ries.

6 DATE OF BIRTH (month, day, and year) Mar. 19-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77.	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Anton Weigert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Ferdinand Ries

(Address) 2004 E. Madison St.

15 Filed Robert P. Harrison, Registrar

14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1921, to Feb 12, 1921, that I last saw h.. alive on Feb 12, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rosied, M. D.

, 19 (Address) 801 N. Raymond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Feb 15 1921
20 UNDERTAKER	ADDRESS
Geo. M. Finh & Son, Funeral Directors & Embalmers.	811 N Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50877 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50877

CERTIFICATE OF DEATH. 82

1-PLACE OF DEATH Baybrew Hospital REGISTERED NO.....

CITY OF BALTIMORE: No. ..... ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Beau

(a) RESIDENCE. No. 128 S. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Euphemia

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisher 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Baybrew Hosp. Balto, Md.

15 Filed 2 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1921, to Feb. 13, 1921, that I last saw him alive on Feb. 13, 1921, and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. F. Smith M. D.

2/14/21 (Address) Baybrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb. 16 1921
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50878 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50878

CERTIFICATE OF DEATH.

37-091 REGISTERED NO.

1-PLACE OF DEATH Mercy Hosp.

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Washington

(a) RESIDENCE. NO. St Elizabeths Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant

(Address) Robert P. Harrison, JOHNS HOPKINS HOSPITAL.

Filed FEB 14 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 10, 1921, that I last saw h alive on Feb 9, 1921, and that death occurred, on the date stated above, at 8.50P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

owd.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Coden of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Patterson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

FEB 14 1921

WM. E. WOODALL

FILL IN ALL BLANKS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lustic

Spec.—8-24-14—M. & T.—2000 Bks.

D.50879 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Baltimore St.; 18 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis F. Krauss.

(Residence in Baltimore: No. 908 N. Baltimore St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 30, 1846 (Month) (Day) (Year)

7-AGE, 75 yrs. 14 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Florist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Krauss

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ferdinand B. Krauss

(Address) 908 N. Baltimore

15-

Filed ..., 191.. Robert E. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 6 1921, to Febr 13 1921, that I saw him alive on Febr 13 1921, and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Hypertrophy

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Pulmonary Oedema

(Duration) yrs. 6 mos. 1 ds.

(Signed) Robert C Metcalf M. D.

2-14-, 1921. (Address) 115 E Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 16, 1921

20-UNDERTAKER George J Smith — ADDRESS 1000 Fayette St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50880 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50880

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 N. Fulton ave 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie C. Schultz

(a) RESIDENCE. No. 704 N. Fulton ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schultz

6 DATE OF BIRTH (month, day, and year) Feby 6. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Hollman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise Sayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Pearl Schultz

(Address) 704 N. Fulton ave

15 Filed Feb 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1920, to Feb 14, 1921, that I last saw her alive on Feb 13, 1921, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? (Clinical)

(Signed) John A Dean, M. D.

(Address) 10 W. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feby. 16. 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50881 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50881

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

REGISTERED NO. 15

CITY OF BALTIMORE: (No 3307 Powhatan Ave. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Tischinger

(a) RESIDENCE. No. 3307 Powhatan Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius J. Tischinger

6 DATE OF BIRTH (month, day, and year) April 10 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Smart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Evitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. John S. Hellen 3307 Powhatan Ave.

15 Filed Feb 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1921, to Feby 12, 1921, that I last saw her alive on Feby 12, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.
Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R. Schaeffer, M. D.

, 19 (Address) 2506 Barclay a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cem Govans	2/15 1921
20 UNDERTAKER	ADDRESS
S. Frew McCully	130 E. Fort.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ll may be properly classified. ...s, so that ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.50882 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.50882

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Gilmor St - ST.: 15 WARD)

2-FULL NAME Henrietta Quigley

(a) RESIDENCE. No. 1523 Gilmor St - ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harris Quigley

6 DATE OF BIRTH (month, day, and year) April 12 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Pencil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Cunningham
(Address) Robert P. Harrison, Cockeysville

15 Filed ..... 19 ..... Registrar

14 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1919, 19..., to Feb 14, 1921, that I last saw h.. alive on Feb 13, 1921, and that death occurred, on the date stated above, at 530 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myelitis Prostatic Enlargement (Paraplegia)

Several Years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Insipidus

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) A. A. Pole, M. D.

19 (Address) 20 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel	Feb. 16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	307 E Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Mad 5840

Dr Condon 750 N North

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D.50883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 West Lanvale ST.; 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F Shower

(a) RESIDENCE. NO. 1033 West Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 23-840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Manchester Maryland

PARENTS

10 NAME OF FATHER: Dr Jacob Shower

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester Maryland

12 MAIDEN NAME OF MOTHER: Mary Ecrihart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: George A Frick

(Address) 1033 W Lanvale

15 Filed FEB 14 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb 14, 1921, that I last saw h[illegible] alive on Feb 14, 1921, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis with Arterio Sclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Vernon N. Condon M. D.

. 19 (Address) 750 N. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Carroll Co Md	2/16 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

Should state OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 50884 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2836 W North Ave. ST.: 15 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie L. Gray

(Residence in Baltimore: No. 2836 W N. Ave. St. 11yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb (Month) 10 (Day), 1852 (Year)

7-AGE, 70 yrs. mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, So not Known

11-BIRTHPLACE OF FATHER (State or Country) So not Known

12-MAIDEN NAME OF MOTHER Mary Schroeder

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pandora Schroeder

(Address) 2836 W. N. Ave

15- Filed B 14 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY* (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

Feb 14, 1921 (Address) 2802 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Frame	Feb 15, 1921
20-UNDERTAKER William Cook	ADDRESS 502 S. Hath Ave

(1) Please write plainly in ink. (2) Information required is important. See instructions on back of certificate.

Gil 2145

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50885 HEALTH DEPARTMENT—CITY OF BALTIMORE √D 50885

CERTIFICATE OF DEATH. 60

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1405 Hollins ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin R. Yeager

(a) RESIDENCE. No. 1405 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (er) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Burt Yeager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Blanch Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Geo Brooks (Address) 17 S Calhoun st

15 Filed FEB 15 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Feb 13th 1921, that I last saw him alive on Feb 13th 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & gross lesions

(Signed) Walter A Cox M. D.

7/14 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2/15th 1921
20 UNDERTAKER	ADDRESS
Robert. Brooks & Son	Calhoun Hollins sts

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D50886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50886.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 N. Calvert ST.; 11 10-09 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Talbot Husband

(a) RESIDENCE. No. 1016 N. Calvert ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md. U.S.A.

PARENTS

10 NAME OF FATHER John J. Husband

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna. U.S.A.

12 MAIDEN NAME OF MOTHER Ann E. Capron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia U.S.A.

14 Informant Mary Lyne Husband
(Address) 1016 N Calvert St.

15 Filed FEB 15 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb. 14th, 1921, that I last saw her alive on Feb 13th, 1921, and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus L. Ohme, M. D.

2/14/1921 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Feb 17 1921

20 UNDERTAKER: J. Wilkins & Sons Co — ADDRESS: Frederick Md. College

Md. V. 366

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50887

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 S Bank St. Ward V)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerardus Smith

(a) RESIDENCE. No. 2008 S Bank St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Stanislawa Bilski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Martin Smith (Address) 2008 S Bank St

15 Filed FEB 15 1921 BOWER A. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, ~~That I~~ attended deceased from Feb 13 21 to Feb 14 21.

that I last saw him alive on Feb 14 21.

And that death occurred, on the date stated above, at 12-30 P. M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1hr ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Stellen M. D.

2-17-21 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 15 1921

20 UNDERTAKER	ADDRESS
John H Eichler	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050888

HEALTH DEPARTMENT—CITY OF BALTIMORE

050888

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 N Bond ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie R Cook

(a) RESIDENCE. NO. 1133 N Bond ST., 18 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): Oct 4, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John C Degraw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jane Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr Mary Smith

(Address): 1133 N Bond St

15 Filed FEB 15 1921 [illegible] JTEK Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/7/21, 19..., to 2/12/21, 19..., that I last saw h[illegible] alive on 2/11/21, 19..., and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J W Blount, M. D.

2/12, 19 (Address) 1302 N Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb 17 1921

20 UNDERTAKER: John J Fields — ADDRESS: 1302 N Fountain St

TION is very important. See instructions on back of certificates.

Md V. 2440 10 c

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050889 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 H. W. Lanvale ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Newton

(a) RESIDENCE. No. 4 West Lanvale ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE: Years 45; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Charlottsville Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Minnie Baker

(Address): 4 West Lanvale Street

15 Filed FEB 15 1921 ROBERT A. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4th, 1921, to Feb. 11th, 1921, that I last saw him alive on Feb. 10th, 1921, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of right side due to Arterio-sclerosis. 040

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Chas. L. Watkins M. D.

, 19 (Address) 39 West Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Buffalo F. Mac Gladrey Co Va

DATE OF BURIAL: Feb 14 1921

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 575 N Eutaw

...be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—8-24-14—M. & T.—2000 Bks.

1050890 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050890

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Washington St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Walter

(Residence in Baltimore: No. 512 N. Washington St.; 71 yrs., 9 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) 3 (Day), 1849 (Year)

7-AGE, 71 yrs. 9 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER, Israel Stumps

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dunbar

13-BIRTHPLACE OF MOTHER (State or Country), Southern

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. A. O'Connor

(Address) 512 N. Washington St.

15-

Filed FEB 15 192, 191.... ROBT. J. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Last 10 yrs 191, to Feb 5 191, that I saw her alive on Feb 4 191, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Injury

(Duration) 20 yrs. mos. ds.

(Signed) Geo. F. Cunning M. D.

Feb 7, 191 (Address) 407 Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel. DATE OF BURIAL, Feb 15, 1917

20-UNDERTAKER H. M. Cauthorn ADDRESS 1124 N Eutaw

Key. 1. 486

important. See instructions on back of certificate. Properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wm Harper

D50891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50891

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 Mine Ave ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harper

(a) RESIDENCE. No. 339 N. Gay ST., ... WARD. .....
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Messenger
(b) General nature of industry, business, or establishment in which employed (or employer) Western Union.
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Harper

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Foote

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant E. C. Cusick
(Address) 350 Benson Ave

15 Filed FEB 15 1921 19 Burial Permit Given ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/29, 19 21 to 2/14, 19 21,
that I last saw h[illegible] alive on 2/14, 19 21,
and that death occurred, on the date stated above, at 6.40 p.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm A. Pudlyk, M. D.

19 (Address) Mine Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Irvington Pk. Dorchester Co. Feb. 15 21

20 UNDERTAKER — ADDRESS

A. S. Marshall 3539 Hall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 N. Washington St.; 8 79 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Wilson

(Residence in Baltimore: No. 2036 N. Washington St. 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1839 (Year)

7-AGE, 81 yrs. 4 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Georgetown Del.

PARENTS.

10-NAME OF FATHER, William Wilson

11-BIRTHPLACE OF FATHER (State or Country) Georgetown Del

12-MAIDEN NAME OF MOTHER Ellen ?

13-BIRTHPLACE OF MOTHER (State or Country), Georgetown Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lydia Wilson

(Address) 2036 Washington Ave

15- Filed FEB 15 1921 ROBERT F. CARTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1917, to Feb 13 1921, that I saw him alive on Feb 13 1921, and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 3 yrs. 7 mos. 29 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jacob Frahn M. D.

Feb 14 1921 (Address) 1823 N. Market St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Mary's Hampden — DATE OF BURIAL: Feb 15, 1921

20-UNDERTAKER: N S Marshall 3339 — ADDRESS: Fait Rd

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050893

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050893

CERTIFICATE OF DEATH.

50

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5150 Bradford St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Szulczewska.

(a) RESIDENCE. NO. 5150 Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Szulczewski

6 DATE OF BIRTH (month, day, and year): April 1st 1858

7 AGE: 63 (Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fannie Pinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Martin Szulczewska
(Address) 513 S. Bradford

15 Filed FEB 15 1921 19 ROBERT J. THAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Feb 14, 1921.

that I last saw h... alive on Feb 13, 1921.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Yes

(Signed) J. Wadenlow M. D.

1921 (Address) 1412 Bradford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Trappe Rd

DATE OF BURIAL: Feb-16 1921

20 UNDERTAKER: Wendell Pippel & Son

ADDRESS: 378 N

MARRIAGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1050894

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050894

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Boreley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wheatley

(a) RESIDENCE. No. 1523 Boreley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Wheatley —

6 DATE OF BIRTH (month, day, and year) Feb 28 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Janitor
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Wheatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Alice Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waverly Md.

14 Informant Alice Smith
(Address) 1523 Boreley St.

15 Filed FEB 15 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Feb 13, 1921, that I last saw h. alive on Feb 12, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hog Ulcer Intestine Duration Years ago (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Feb 13, 1921 (Address) #1209 Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Feb 16 1921

20 UNDERTAKER Joseph a Farrell

ADDRESS 239 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Henry E. Potts

Spec.—6-9-19—H. P. Co.—1000 Blks.

1950895 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 1950895

CERTIFICATE OF DEATH. 92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital WARD) 24

2-FULL NAME Mr Henry Earl Potts

(a) RESIDENCE. NO. 1309 Hull St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 6, 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): to R. C. & T. Co. Rapid Coaling & transfer Co
(c) Name of employer: Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H Potts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine Sheehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. J. H. Potts
(Address) 1309 Hull St.

15 Filed FEB 15 1921 ROBERT J. BRADY Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1 1921, to Feb 13, 1921, that I last saw h/ alive on Feb 13, 1921 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 1309 Hull St

Did an operation precede death? Yes Date of 2/4/21

Was there an autopsy? No

What test confirmed diagnosis? by Coagulin

(Signed) H. L. Hoffman, M. D.

, 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Feb. 16 1921

20 UNDERTAKER: Margaret A. Flynn — ADDRESS: 14 W Lexington St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050896

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050896

92

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N. Port ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Borey.

(a) RESIDENCE. No. 521 N. Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of (or ~~WIFE~~ of) the late Artemise Borey

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ferdinand Borey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Mrs. Catherine 1704 N. Calvert St

15 Filed FEB 15 1921 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14. 9 A.M., 1921 to Feb. 14. 3 P.M. 1921, that I last saw him alive on Feb. 14, 1921, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Percussion

(Signed) Joseph S. Talkin, M. D.

, 19 (Address) 2212 Jefferson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Feb 17 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050897 HEALTH DEPARTMENT—CITY OF BALTIMORE 050897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 S. Carey 1ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina. H. Wiegand

(a) RESIDENCE. No. 1314 S. Carey 1st WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced (write the word)~~
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John W. Wiegand

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Winer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John W. Wiegand
(Address) 1314 S Carey st

15 FEB 15 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Feb 14, 1921, that I last saw h[illegible] alive on Feb 13, 1921, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

What there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) J. M. Dorsett, M. D.

19 (Address) 621 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 16 19 21
20 UNDERTAKER	ADDRESS
Jos Jourdens Son	2073 Pac

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could give no other history

D50898 HEALTH DEPARTMENT—CITY OF BALTIMORE. 64 D50898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1911 W. Lafayette Ave St.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank F. Gunnerhausen

(Residence in Baltimore: No. 1911 W. Lafayette Ave St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, April 12, 1846
(Month) (Day) (Year)

7-AGE, 74 yrs. 10 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Restaurateur

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss M. N. Gunnerhausen

(Address) 1911 W. Lafayette Ave.

15- FEB 15 1921

Filed....., 191.... ROBERT J. BRAUER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 6 yrs..... mos..... ds.

(Signed) J. T. A. Hennessy M. D.
(Coroner)

Feb 14, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Feb 17 '21

20-UNDERTAKER Feltman & Co — ADDRESS 1723 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should write plainly. Name should be stated EXACTLY.

Henry Pope

050899 HEALTH DEPARTMENT—CITY OF BALTIMORE 050899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Township Hardesty Center ST.: 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Pope

(Residence in Baltimore: No. 681 Josephine St (3 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

9-BIRTHPLACE, (State or Country), Atlanta Ga

PARENTS.

10-NAME OF FATHER, Randal Pope

11-BIRTHPLACE OF FATHER (State or Country), Ga.

12-MAIDEN NAME OF MOTHER Nancy

13-BIRTHPLACE OF MOTHER (State or Country), Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Pope

(Address) 681 Josephine St

15- FEB 15 1921 ROBERT F. KRAUTER Registrar.
Filed ....., 191.... Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burn, no bed
Sores - Causing Exhaustion
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Edward Gill Grason M. D.
(Coroner.)
Feb 15 21, 191.. (Address) 1004 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Feb 19, 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 1423 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50900 HEALTH DEPARTMENT—CITY OF BALTIMORE D50900

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Saratoga & Calvert St.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maria Adams Miller

(a) RESIDENCE. NO. 12 W Read St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. J. Miller. (Dec)

6 DATE OF BIRTH (month, day, and year) Aug. 20. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Mary Grey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant (Address) Hosp. Record. Mercy Hosp

15 Filed FEB 15 1921 ROBERT E. LAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1921, to Feb 13, 1921, that I last saw her alive on Feb. 13, 1921, and that death occurred, on the date stated above, at 9:12 A m.

The CAUSE OF DEATH* was as follows:

Rupture of Cerebral Vessels (Artery)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward L. Kaufman M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Feb 15 1921
20 UNDERTAKER Henry H Jenkins Sons Co	ADDRESS McCulloh & Orchard Sts

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1650901

HEALTH DEPARTMENT—CITY OF BALTIMORE

1650901

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1203 E. Preston ST. 10 WARD)

2-FULL NAME Mildred M. Moreland

(a) RESIDENCE. NO. 1203 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. -- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5-1901.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloisinger & Son.

9 BIRTHPLACE (city or town)
(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Wade H. Moreland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Grace Sharp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Wade H. Moreland
(Address) 1203 E. Preston St.

15 Filed ..... 19 ..... FEB 15 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1921, to Feb. 13, 1921, that I last saw h[illegible] alive on Feb. 13, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) — yrs. — mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

. 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	2/15/21.

20 UNDERTAKER Chas. J. Evans & Son ADDRESS 118 W. Mt. Royal Ave

Sign plainly in ink. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Carrie Caplan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50902

CERTIFICATE OF DEATH.

120 D50902

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Carrie Caplan

(Residence in Baltimore: No. 100 Jackson Place St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Nov 2 (Month) (Day), 1885 (Year)

7-AGE, 35 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Goldman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Minkow

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto St

15-

Filed SEP 15 1921 191... COMPT. & TREASR. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Feb 15 1921, that I saw h[er] alive on Feb 15 2m 1921, and that death occurred, on the date stated above, at 1 am m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Uraemia 1d

1

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. mos. 1 ds.

(Signed) Benj. Sacks M. D.

Feb 15, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 17 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? 100 Jackson Place

Former or usual residence " " "

19-PLACE OF BURIAL OR REMOVAL, Hebrew Wash Road — DATE OF BURIAL, 2-17-, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50903 HEALTH DEPARTMENT—CITY OF BALTIMORE D50903

CERTIFICATE OF DEATH. 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Lewis

(a) RESIDENCE. No. 920 E Baltimore St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —— 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant Owner

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A. Lewis
(Address) 1411 E Balto St

15 Filed FEB 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1921, to Feb 14th, 1921, that I last saw h... alive on Feb 14th, 1921, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia (Pneumococcic)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Hand, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Herring Run	Feb 15 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50904 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D50904

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 S Fitzhugh ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J Merriken

(a) RESIDENCE. No. 39 S Fitzhugh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Merriken

6 DATE OF BIRTH (month, day, and year) Oct 10-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	04	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Knabe Piano Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David W. Merriken

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Toudon

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Robert E. L. Marr (Address) 107 W Eutaw Ave

15 Filed FEB 15 1921 ROBERT I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Feb 14, 1921, that I last saw him alive on Feb 14, 1921, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ARTERIO-SCLEROSIS.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Bernard S. French M. D.

2/15, 1921 (Address) 1707 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	2/17 1921
20 UNDERTAKER Robert Brokenborough	ADDRESS Howard & Hollins St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D50905

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1424 Ward St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Young

(a) RESIDENCE. NO. 1424 Ward ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) Out

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Thomas Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Canada

14 Informant Nallie Jones
(Address) 1224 Bayard St

15 Filed FEB 15 1921 ROBERT [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 31, 1921, to Feb 14, 1921, that I last saw him alive on Feb 14, 1921, and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis left side

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dain, M. D.

2/16 1921 (Address) 1330 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 16 '21
20 UNDERTAKER	ADDRESS
Daniel Easton	946

THAT it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.
TION is very important. See instructions on

D50906 HEALTH DEPARTMENT—CITY OF BALTIMORE D50906

CERTIFICATE OF DEATH.

REGISTERED No. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1424 Monroe alley St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Smaths Williams

(Residence in Baltimore: No. 1424 Monroe alley St.; yrs., mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col.	Sing.

6-DATE OF BIRTH, April 10th, 1919.
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Laurence Williams

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Lottie Lucy

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Proctor

(Address) 1747 Eastern Ave

15- FEB 15 1921 ROBERT B KRAUSE
Filed ....., 191... Vital Statistics Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute lung trouble

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H. Feldman M. D.
(Coroner)

....., 191... (Address) 2-5-21

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn cemetery	Feb 15 1921
20-UNDERTAKER	ADDRESS
Mrs Routt a Elliott	1725 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

658-8 10,450 c

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.50907 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50907

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Stinson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Elmer Ochs

(a) RESIDENCE. NO. 304 Stinson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE White

5 ~~Single, Married, Widowed, or Divorced (write the word)~~

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ ~~or, WIFE of~~

6 DATE OF BIRTH (month, day, and year) Dec: 13, 1920

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER George Ochs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine B. Stocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Ochs. (Address) 504 Stinson St.

15 Filed 1921 Robert P. Harrison, Registrar

B15 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 14, 1921, that I last saw h. in alive on July 13, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) P. G. Dill M. D.

17, 1921 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem.

DATE OF BURIAL Feb: 16 1921

20 UNDERTAKER C. W. Dill.

ADDRESS 3109 Fred'k Ave.

TION is very important. See instructions on back of certificates. t may be properly classified. Exact statement of OCCUPA- should state

(Lewandowski)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50908

CERTIFICATE OF DEATH.

91-084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 S Castel ST.: 2 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lewandowski

(a) RESIDENCE. No. 407 S Castel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Agnes Kunicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank Lewandowski (Address) 407 S Castel

15 Filed 2 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/12, 1921, to 2/14, 1921, that I last saw h[illegible] alive on 2/14, 1921, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wm A. Redlich, M. D.

2/15 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 16 1921
20 UNDERTAKER	ADDRESS
John M Weber 1803	Bank St

TION is very important. See instructions on back of certificate.

that it may be properly classified. Exact statement of OCCUPA-

D.50909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50909

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1560 Clifton Ave ST.: 13 104 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Eleanor Cooks

(Residence in Baltimore: No. 1560 Clifton Ave. St. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, December 28, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 17 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto - Md

PARENTS.

10-NAME OF FATHER, David E. Cooks.

11-BIRTHPLACE OF FATHER (State or Country). Balto Co. Md.

12-MAIDEN NAME OF MOTHER Myrtle Meyers

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Meyers

(Address) 1560 Clifton Ave

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

B 15 1921 Burial Permit Clerk.

Funeral - 3632 Roland Ave

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Harrison M. D.
(Coroner.)

Feb. 15 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet	Feb. 16, 1921

20-UNDERTAKER William Cook ADDRESS 603 N. Nath Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50910 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50910

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13½ (St.) N Monroe Park (Ward) 25 91 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Polcak

(a) RESIDENCE. (Usual place of abode) NO 13½ St N Monroe Park ST., WARD. 25

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Polack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Rose Cedilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Thomas Polcak

(Address) 13½ St Monroe Park

15 Filed ....., 19.... Robert F. [illegible] Registrar

Burial Permit Clerk

B 5 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 8 1921, to Feby 15 1921, that I last saw h[illegible] alive on Feby 14 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) none

(duration) ....yrs. ....mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo S McKeller M. D.

Feb 1 1921 (Address) Monroe Park md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakhill Cemetery	2/17 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

TION is very important. See instructions on back of certificates.

be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 50911

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Fair Oak Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Stran

(a) RESIDENCE. No. 601 Fair Oak ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jean H Stran

6 DATE OF BIRTH (month, day, and year) March 13/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Franklin H Stran

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Bleet

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Jean H Stran
(Address) 601 Fair Oak Ave

15 Filed 3 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Feb. 15, 1921, that I last saw h— alive on Feb. 12, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A Dean, M. D.

, 19 (Address) 101 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cem Falls Rd	Feb 17 1921

20 UNDERTAKER H. Black ADDRESS 602 S Paca

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50912 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50912

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1852 West Fayette St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Timothy Hutson

(a) RESIDENCE. No. 1852 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Hutson

6 DATE OF BIRTH (month, day, and year): Sept 19, 1873

7 AGE: Years 47 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Acid Maker.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Timothy N. Hutson

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Catholic Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant (Address): Rachel Jane Hutson 1852 W Fayette

15 Filed: FEB 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-15 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Feb 15, 1921, that I last saw h.im alive on Feb 15, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmoghio

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary): Intra Cranial Sarcoma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Hammonbach, M. D.

Feb. 19 21 (Address) 835 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia S. Carolina — DATE OF BURIAL: 2/16 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.50913 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 50913

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 E Chase St. 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Dooling

(a) RESIDENCE. No. 1003 E Chase St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Dec 18, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis E Dooling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas Balto, Co Md

12 MAIDEN NAME OF MOTHER Ellen Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Marie Ellen Dooling

(Address) 1003 E Chase St

Filed FEB 15 1927

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1927

17 I HEREBY CERTIFY, That I attended deceased from Feby 14, 1921, to Feby 15, 1921, that I last saw him alive on Feby 14, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) A. G. Hornstein, M. D.

2/15, 1921 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Joseph Cemetery Texas Balto Co Md Feb 16 1921

20 UNDERTAKER ADDRESS

Elmer H Conklin 824 E Eager

IMPORTANT.—Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050914

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050914

92

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 244 (Schroeder) ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Johnson

(a) RESIDENCE. No. 244 Schroeder ST., ... WARD. .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1, 1920

7 AGE Years — Months 8 Days 13 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Mason Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Hoss

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Hoss
(Address) 244 N Schroeder St

15 Filed FEB 16 1921 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/9/ 1921, to 2/14/ 1921, that I last saw her alive on 2/14/ 1921, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Bacteriological

(Signed) W H Hobbitt, M. D.

2/15 1921 (Address) 767 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 16 1921
20 UNDERTAKER John H Soadin	ADDRESS 142 Uxtick St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50915

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E. Hoffman ST.; 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina R. Napfel

(a) RESIDENCE. No. 1628 E. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Edward Napfel

6 DATE OF BIRTH (month, day, and year) June 17 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) md.

PARENTS

10 NAME OF FATHER Thomas Forstner

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Louisa Grob

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. A. B. Sommerlock

(Address) 1702 N. Bethel St

15 Filed FEB 16 1921 ROBERT A. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1921, to Feb. 15, 1921, that I last saw h.. alive on Feb 15 1921, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) Thos F. Stevens, M. D.

2/15, 1921 (Address) 2866 Kearsford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb. 18 1921
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E. Lanvale St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50916

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 843 W Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Warner

(Residence in Baltimore: No. 843 W Balto St., 75 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1847 (Year)

7-AGE,	If LESS than 1 day,
66 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Howard

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jennie Wyatt

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Snyder

(Address) 1120 W Cross St

15- FEB 16 1921 Filed ROBT. J. KRAUTH Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Feb 14 1921, that I saw her alive on Feb 14 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Uremia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) H. S. E. Thomas M. D.

Feb 16, 1921 (Address) 1320 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Feb 16, 1921

20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Important. See instructions on back of certificate. Inquiry concerning Cause of Death or Statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 50917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50917

CERTIFICATE OF DEATH.

REGISTERED No. C 1791

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N. Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew Martin

(Residence in Baltimore: No. 826 N. Stricker St.; ..... yrs., 6 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1852 (Year)

7-AGE, 69 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(h) General nature of industry, business, or establishment in which employed (or employer): 10

9-BIRTHPLACE, (State or Country) Wexford Co Ireland

PARENTS.

10-NAME OF FATHER, Patrick Martin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Mc Cormick

13-BIRTHPLACE OF MOTHER (State or Country), Wexford Co Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matthew F. Martin

(Address) Wade Ave Catonsville Md

15-

FEB 16 1921 Filed ..... 191.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1921, to Feb 14 1921, that I saw h— alive on Feb 14 1921, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Wm. Courtney M. D.

Feb 16, 1921. (Address) 906 N. Stricker St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 15 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Catonsville Md.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER Joseph L. B Cook ADDRESS 1003 W. Balto St

250918 HEALTH DEPARTMENT—CITY OF BALTIMORE 250918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 631 W Mulberry St.: 4 WARD) REGISTERED No. C 79

2-FULL NAME Sarah Parker—

(Residence in Baltimore: No. 631 W Mulberry St.; 50 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. W. Parker.

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Rachael Osborn

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza Parker

(Address) 631 W. Mulberry st

15- FEB 16 1921 ROBERT J. KRAUTER

Filed ....., 191.... Burial Permit ..... Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 2 ..... 14 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar disease of the heart

..... (Duration) ..... yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Forsyth M. D.
(Coroner)

2-16-, 1921 (Address) 117 N Sarato

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, 2/17/21, 19....

20-UNDERTAKER Samuel W. Chasesson — ADDRESS 1406 Mosher st

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L50919 HEALTH DEPARTMENT—CITY OF BALTIMORE L50919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 519 Vincent St.: 19 WARD) REGISTERED No. C

2-FULL NAME Malinda Corbin

(Residence in Baltimore: No. 519 Vincent St.: 2 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ... (Month) November (Day) ....., 1872 (Year)

7-AGE, 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Washington Reed

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Betsy Reed

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Betty Brooks

(Address) 715 N. Edmondson

15- Filed FEB 16 1921, 19.. ROBERT J. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Feb. 13, (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Lead disease

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 14, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Middle Sec Ct Va Mch

DATE OF BURIAL, Feb. 16, 1921

20-UNDERTAKER Wm. H. Clune Son

ADDRESS 1400 Mosher St

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—6-9-1f—H. P. Co.—1000 Bks.

1050920 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050920

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 47 Bellevieu Ave. ST. Rosldurg WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Jane Robinson

(a) RESIDENCE. No. 47 Bellevieu Ave. ST. Rosldurg WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George M. Robinson

6 DATE OF BIRTH (month, day, and year) March 19th 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Steever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant George M. Robinson

(Address) Rosldurg Md.

15 Filed FEB 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Feb 14, 1921, that I last saw h.e alive on Feb 14, 12 M., and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Sp. & Cult. exams.

(Signed) C. G. Rinck M. D.

Feb. 19 21 (Address) 120 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 17 1921
20 UNDERTAKER	ADDRESS
Frank Lassahn & Son	Fallston Md

D50921 HEALTH DEPARTMENT—CITY OF BALTIMORE D50921

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 1475 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida A. White

(Residence in Baltimore: No. 8 Mother St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., (Month) (Day) 1875 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Dodd

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Francis Embrown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. White

(Address) 226 S. Carey St

15- FEB 16 1921 Filed ....., 191... ROBERT J. KRAUTER Registrar. Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains deserlbed above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull (Taken by auto)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Feb. 16, 1921 (Address) 1659 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb. 17, 1921

20-UNDERTAKER, M. Tabor & Son — ADDRESS 819 W. North Ave

CAUSE OF DEATH: In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D50922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50922

CERTIFICATE OF DEATH.

1679

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Byrne,

(Residence in Baltimore: No. 1120 N Stricker St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1861 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick King

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Burke

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard .....

(Address) 1120 N. Stricker St.

15- FEB 16 1921 Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/9 1921, to 2-15 1921, that I saw h[er] alive on 2-13 1921, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

..... (Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Bernard Cross M. D.

2/15, 1921. (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER Martin Fahey Sons

ADDRESS 1500 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D50923 HEALTH DEPARTMENT—CITY OF BALTIMORE D 50923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 5 120

CITY OF BALTIMORE (No. 1122 Low St., St. 5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Walker

(Residence in Baltimore: No. 1122 Low St. St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Unknown, 1886
(Month) (Day) (Year)

7-AGE, ~~[illegible]~~ 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Orange Va

PARENTS.

10-NAME OF FATHER, William Walker

11-BIRTHPLACE OF FATHER (State or Country), Orange Va

12-MAIDEN NAME OF MOTHER Lettia Raglan

13-BIRTHPLACE OF MOTHER (State or Country), Louisa Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Egona Walker

(Address) Orange Va

15- FEB 16 1921 ROBERT S. BRAUCHER Registrar.
Filed ....., 191.... Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Mike M. D.

(Coroner) T. Earl

2-14-, 192[illegible] (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Orange Va	Feb 16, 21
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

Please write plainly. Use ink. Do not use lead pencil. Physicians should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 50924

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 50924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Linden Ave St. 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lady Phebe Schaefer

(Residence in Baltimore: No. 2201 Linden ave St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 22, 1873
(Month) (Day) (Year)

7-AGE, 47 yrs. 1 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Non
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, James F Lednum

11-BIRTHPLACE OF FATHER (State or Country) Baltimor City

12-MAIDEN NAME OF MOTHER Sarah J Frizzell

13-BIRTHPLACE OF MOTHER (State or Country) Baltimor City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St John Schaefer

(Address) 2201 Linden Ave

15- FEB 16 1921 Filed ....., 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Feb 14 1921, that I saw h[illegible] alive on Feb 14 1921, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Nephritis

(Duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 1 yrs. ..... mos. 1 ds.

(Signed) W. D. Hewitt M. D.

Feb 15, 1921 (Address) 2220 Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb. 17, 1921

20-UNDERTAKER George J Smith — ADDRESS 1000 W Fayette St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

L50925 — L50925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3914 Woodbine ave (Institution) ST. 28 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Coulon

(Residence in Baltimore: No. 3914 Woodbine ave St. L'ft yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept. 8, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... "

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas E. Coulon

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Marcella E. Tingley

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos E. Coulon

(Address) 3914 Woodbine Ave

15-FEB 16 1921 ROBERT A. BRUDER

Filed....., 191.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 16 1921, that I saw h... alive on Feb 15 1921, and that death occurred, on the date stated above, at 4-35 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Influenza Cold (Primary)

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) Edward F. Leonard M. D.

Feb 16, 1921. (Address) 2311 Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. 8 mos. 8 ds. In the State 5 yrs. 8 mos. ds.

Where was disease contracted, if not at place of death? 3914 Woodbine Ave

Former or usual residence 3914 Woodbine Ave

19-PLACE OF BURIAL OR REMOVAL, Woodlawn | DATE OF BURIAL, Feb 16, 1921

20-UNDERTAKER Wm Lock 502 E Pratt | ADDRESS

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

050926 HEALTH DEPARTMENT—CITY OF BALTIMORE 050926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. J. Compton Stifler, Sr.

(a) RESIDENCE. NO. Del Air Md. ST. WARD. (Bel-Air Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 24 ds. How long in U. S., If of foreign birth? 59 yrs. 0 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Jan. 27 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER C. D. Stifler

11 BIRTHPLACE OF FATHER (city or town) Penna.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Clary

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mercy Hosp. Record
(Address) Baltimore Md

15 FILED FEB 16 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1921, to 2/15, 1921, that I last saw him alive on 2/15, 1921, and that death occurred, on the date stated above, at 2:55 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis A. Ridgely, M. D.

2/17, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bel-Air - Md.	Feb 16 1921

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

050927 HEALTH DEPARTMENT—CITY OF BALTIMORE 050927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Matthew Knight Potter

(a) RESIDENCE. No. Church Home-Infirmary. ST., WARD. (Wilmington, Del)
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred (Ab't) 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 31 yrs. 1 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Potter.

6 DATE OF BIRTH (month, day, and year) Jany-8-1890.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. In employ of

(b) General nature of industry, business, or establishment in which employed (or employer) The Pullman Company

(c) Name of employer at Wilmington, Del.

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William S. Potter.

11 BIRTHPLACE OF FATHER (city or town) Chile
(State or country) South America.

12 MAIDEN NAME OF MOTHER Carey Reeves.

13 BIRTHPLACE OF MOTHER (city or town) Wilmington
(State or country) Delaware.

14 Informant Mr. D. R. Potter, (brother)
(Address) Clarksburg, West Va.

15 Filed FEB 16 1921, 19.... [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1920, to Feb. 14, 1921,
that I last saw h[illegible] alive on " " , 1921,
and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of kidney

2 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Excision of mass

(Signed) W. D. Noble (per McDonagh) M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from violent causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb-16-/21
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified, so that it m[illegible] in plain terms, so

Spec.—8-24-14—M. & T.—2000 Bks.

DAVIS

D50928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50928

CERTIFICATE OF DEATH.

REGISTERED No. C 15-151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1556 N. Fremont Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Elizabeth Davis

(Residence in Baltimore: No. 1556 N Fremont Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
yrs. mos. 2 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Davis

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Mason

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Davis

(Address) 1556 N. Fremont Ave.

15- Filed FEB 16 1921 for Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/14/21 191, to 2/15/21 191, that I saw h— alive on 2/14/21 191, and that death occurred, on the date stated above at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis days

(Duration) yrs. mos. ds.

(Signed) H. Leo Ellis M. D.

2-15-, 1921 (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Feb 16, 1921

20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

050929

HEALTH DEPARTMENT—CITY OF BALTIMORE

050929

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Plymouth Hall Apts ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ansel Mandelbaum

(a) RESIDENCE. NO. N.E. Cor Madison Ave & Mt Vernon Pl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Blanche Mandelbaum

6 DATE OF BIRTH (month, day, and year) Dec 10th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) Wholesale Hats
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Helen Mandelbaum
(Address) Plymouth Hall

15 Filed FEB 16 1921 ROBERT J. REUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Feb 15 1921, that I last saw him alive on Feb 15 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Sclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Hildebrandt M. D.

Feb 19 21 (Address) 1720 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bal Hebrew Cem	Feb 17th 1921
20 UNDERTAKER	ADDRESS
H. Levi Sondheim	1184 W. Pratt St. Mt Reg at Cem

IMPORTANT. PHYSICIANS should state DISEASE CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 50930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50930

CERTIFICATE OF DEATH.

150

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 1800 David Hill St.: 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Garrett

(Residence in Baltimore: No. 1800 David Hill St.; yrs. 20 mins mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	Sing

6-DATE OF BIRTH, Feb. (Month) 13 (Day), 1921 (Year)

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Single

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Garrett

11-BIRTHPLACE OF FATHER (State or Country), Arkansas

12-MAIDEN NAME OF MOTHER Mary E. Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Garrett

(Address) 1800 David Hill Ave

15- Filed FEB 16 1921 191.... ROBERT B CRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coll (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale, 20 min, (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

....(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hennessy M. D. (Coroner.)

Feb. 14. 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Feb 15 1921
20-UNDERTAKER James H Dems	ADDRESS 1303 Bernerman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D50931 HEALTH DEPARTMENT—CITY OF BALTIMORE D50931

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Susie Coates ST.: 15 WARD)
2-FULL NAME 1422 Saratoga St.
(Residence in Baltimore: No. 1422 Saratoga St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female
4-COLOR OR RACE: colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widow

6-DATE OF BIRTH: ...January..., 1872
(Month) (Day) (Year)

7-AGE: 49 yrs. mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Nathan King
11-BIRTHPLACE OF FATHER (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Susie Brooks
13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss R. Coates
(Address) 1422 Saratoga St.

15- FEB 16 1921 ROBERT A. KAUFFER
Filed....., 191.... Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Feb. 14..., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.
The CAUSE OF DEATH* was as follows:
...Lobar Pneumonia
(Duration)...yrs. 1 mos. 7 ds.
CONTRIBUTORY (Secondary) no history
(Duration)...yrs...mos...ds.
(Signed) J. C. Hemmeter M. D.
(Coroner.)
Feb 15, 1921 (Address) 2532 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion
DATE OF BURIAL, Feb 16, 1921.
20-UNDERTAKER JAMES H. DENT
ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1050932

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050932

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ahrens

(a) RESIDENCE. NO. 119 N. Pearl St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Divorced

5a ~~If married, widowed, or~~ divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38. yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Ahrens.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlestown SC Do not know.

12 MAIDEN NAME OF MOTHER Barbara White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany Do not know

14 Informant (Address) Mrs. J. Ahrens. 418 E. Fort Ave.

15 Filed FEB 16 1921 ROBT. J. BRAGER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 15 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-13, 1921, to 2-15, 1921, that I last saw h[e] alive on 2-15, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Both Lungs

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Finnegan, M. D.

, 19 (Address) Woodlawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	2/18 1921
20 UNDERTAKER	ADDRESS
J. J. Fahy & Son	1318 Light St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D50933

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1082 D50933

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 536 N. Eden St ST.: 5 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Brown

(Residence in Baltimore: No. 536 N. Eden St St.: (yrs. 6) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE C

5-~~SINGLE, MARRIED WIDOWED OR DIVORCED~~ (Write the word) Married

6-DATE OF BIRTH Cant state., 1878
(Month) (Day) (Year)

7-AGE 43 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work HW
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Va
Live in Balt-6 years

PARENTS

10-NAME OF FATHER Cant State.

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Amanda Allen

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Mason

(Address) 536 N Eden St

15- FEB 16 1921 Filed ..... 191 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 12, 1921
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 11, 1921 to July 12 1921, that I saw h[illegible] alive on July 11, 1921, and that death occurred, on the date stated above, at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix.

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) General Peritonitis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Albert L. Levy M. D.

2/16/1921 (Address) 1207 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL FEB 16 1921

20-UNDERTAKER Commissioner Health ADDRESS 1225 Eastern Ave

For Wm. E. WOODALL.

JOHNS HOPKINS HOSPITAL

If not buried, cremated or removed, by whom disposed of? .....

If interment, cremation or removal is not made within 24 hours after death, a permit must be obtained from the Health Officer.

IT IS VERY important that every item of information should be carefully supplied. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D50934 HEALTH DEPARTMENT—CITY OF BALTIMORE D50934

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Druid Hill Ave St.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mable Madden

(Residence in Baltimore: No. 1131 Druid Hill Ave St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 16 (Day), 1919 (Year)

7-AGE, 1 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(s) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank E. Madden

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Amelia Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Madden

(Address) 1131 Druid Hill Ave

15- FEB 16 1921 ROBERT J. KRAUTER

Filed....., 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1919, to Feb 16 1921, that I saw h.r alive on Feb 13 1921, and that death occurred, on the date stated above, at 11 42 a.m.

The CAUSE OF DEATH* was as follows:

Intoxication Interstitial Nephritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) M

(Duration) yrs. mos. ds.

(Signed) A. L. Hopkins M. D.

2/16, 1921 (Address) 33 McCulloh Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dark Hill — DATE OF BURIAL, Feb 18, 1921.

20-UNDERTAKER Samuel Hensley — ADDRESS 518 N Eutaw

Important. See instructions on back of certificate. Every item should be properly classified. Exact statement of OCCUPATION is very

Spec. 6-9-20—H. P. Co.—1000 Blks.

D 50935 (1921)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50935

1-PLACE OF DEATH

REGISTERED NO. 40

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hastings

(a) RESIDENCE. No. 2462 Fairmount Av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~1 yrs.~~ mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Hastings

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indianola Reedville Va

PARENTS

10 NAME OF FATHER Austin Dodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J. H. Hospital records (Address)

15 Filed FEB 16 1921 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 1921 to Feb 15 1921, that I last saw h[illegible] alive on Feb 15 1921, and that death occurred, on the date stated above, at 2 55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Jan 31, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo Carter, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reedville Va	2/16 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks. John W. Augustyniak. 1050936

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050936

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 806 S. Bond ST. 3 - WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Augustyniak

(a) RESIDENCE. NO. 806 S Bond ST., 3 - WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Augustyniak

6 DATE OF BIRTH (month, day, and year) Dec - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	2	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Odd jobs
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph Augustyniak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frances Augustyniak. (Address) 806 S. Bond St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/14, 1921, to 2/14, 1921, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 2 7 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wm A Bultoff, M. D.

2/18, 1921 (Address) 1023 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Feby 18" 1921.

20 UNDERTAKER: M. F. Sadowski. ADDRESS: 905 S. Ann

6 1921 Burial Permit Clerk.

PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50937

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Dalow.

(a) RESIDENCE. No. The Bretan ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
48 yrs.		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Teacher 68
(b) General nature of industry, business, or establishment in which employed (or employer): Public School
(c) Name of employer: Balto Md.

9 BIRTHPLACE (City or town)
(State or country)

PARENTS

10 NAME OF FATHER: John Dalow

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Margaret Tonry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Do not know.

14
Informant
(Address): Anna Dalow

15 Filed Robert E. Harrison Registrar
6 1921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15- 1921

17
I HEREBY CERTIFY, That I attended deceased from
Dec. 1920, to 2-15 1921,
that I last saw h alive on 2-15 1921,
and that death occurred, on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Finnegan, M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/19 1921
20 UNDERTAKER	ADDRESS
Chas E. Evans & Son	118 W Mt Royal Ave

FROM is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.50938 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50938

CERTIFICATE OF DEATH.

71

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Glen Edward Av. ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Posedenti

(a) RESIDENCE. NO. 402 Glen Edward Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Angio Posedenti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary DeLorie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas Maryland

14 Informant Angio Posedenti
(Address) 402 Glen Edward Ca

15 Filed FEB 16 1921 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to Feb 16, 1921, that I last saw h alive on Feb 16, 1921, and that death occurred, on the date stated above, at 1210 a m.

The CAUSE OF DEATH* was as follows:

Convulsions Few hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Teething infancy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L L Richardson, M. D.

Feb 16, 1921 (Address) 1132 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M Vincent	Feb 18 21

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

FEB 16 1921

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50939 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50939

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Goodwood Gardens, Roland Park 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bramble

(a) RESIDENCE. No. 210 GOOdwood Gardens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~female~~	white	widowed

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Lenox L.Bramble

6 DATE OF BIRTH (month, day, and year) May 22.1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Washington Slacomb

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co.
(State or country) Maryland

14 Informant Mrs.George T.Phillips
(Address) 210 Goodwood Gardens

15 Filed Robert P. Harrison, Registrar
Feb 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.15th. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 9, 1921, to Feby 15, 1921, that I last saw h alive on Feby 14, 1921, and that death occurred, on the date stated above, at 11;20 A m.

The CAUSE OF DEATH* was as follows:

Uraemia Entero-Colitis Infection
Arterio Sclerosis — Coma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Micro and Chemical

(Signed) Lee L. Mottu, M. D.

, 19 (Address) 6 W. Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 17 '21
20 UNDERTAKER	ADDRESS
H.E.Hughes & Bro.	Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50940 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50940

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Goschen

(a) RESIDENCE. NO. 3714 E. Lombard ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Goschen

6 DATE OF BIRTH (month, day, and year) Dec. 21-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frank Zymnia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Goschen
(Address) 3714 E. Lombard St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

3161921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14- 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1921, to 2-14-, 1921, that I last saw her alive on 2-14-, 1921, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. valvular heart disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2-3-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Mann, M. D.

2-14-1921 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Feb 17 1921
20 UNDERTAKER Lilly & Zeile.	ADDRESS 403 S. Mo. St.

PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for Prolapse of Uterus, after which she moved around some time and seemed to be in good Physical condition

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50941 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50941

CERTIFICATE OF DEATH

372

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 8 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Brown

(a) RESIDENCE. NO. Bay View Hospital ST. WARD.
(Usual place of abode) 2304 E. Lafayette ave
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Time Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Unfried

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bay View Hosp. (Address) Balto, Md.

15 Filed Robert P. Harrison, Registrar

FEB 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1920, to Feb. 15, 1921, that I last saw h[illegible] alive on Feb. 15 1921 and that death occurred, on the date stated above, at 1515 P. m.

THE CAUSE OF DEATH* was as follows:

General Paralysis (Synh Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lues (suspected)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) N. G. Edwards, M. D.

2/19/21 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	2/17 1921
20 UNDERTAKER Robert Brockerson	Undertaker Calhoun Hollins 20

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50942 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Frieda ave ST.: Lauraville 27 WARD) REGISTERED No. 19

2-FULL NAME Miss Mary Ellen Carter

(a) RESIDENCE. No. 105 Frieda ave ST., Lauraville WARD. Long Green Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 80 yrs. 7 mos. 22 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1839

7 AGE — Years: 81 — Months: 7 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Long Green Balto Co. Md.

PARENTS

10 NAME OF FATHER: Dennis Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Dethia Talbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md

14 Informant: D. W. Carter
(Address): Long Green Balto Co Md.

15 Robert P. Harrison, Registrar

1 67 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 7, 1921, to Feby 16, 1921, that I last saw her alive on Feby 10, 1921, and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Gorsuch, M. D.

2/16 1921 (Address) Hamilton, Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green. Balto. Co.

DATE OF BURIAL: Feb 17 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

erms, so that it

TIONS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050943

HEALTH DEPARTMENT—CITY OF BALTIMORE

1050943

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 E. 28th St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Pfaff

(a) RESIDENCE. No. 502 E 28th St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Pfaff

6 DATE OF BIRTH (month, day, and year) Jan 27-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Hesse Germany

PARENTS

10 NAME OF FATHER Mr. Engelhaupt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant George E. Pfaff (Address) 502 E. 28th St.

15 Filed FEB 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Feb 15 1921, that I last saw h[illegible] alive on Feb 9 1921, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Nursing

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Stephen Bunk M. D.

2/16 1921 (Address) 2044 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	2-17-1921

20 UNDERTAKER W. J. Tuchmeod Sons ADDRESS Baltimore

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1050944 HEALTH DEPARTMENT—CITY OF BALTIMORE 1050944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Maryland Avenue ST.: 17 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Gertrude Hare

(a) RESIDENCE. No. 2017 Maryland Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Hare

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John McCarthy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Coleman

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Mrs. Ella McCarthy
(Address) 2017 Maryland Avenue

15 Filed FEB 17 1921 [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1920, to Feb. 13th, 1921, that I last saw h.. alive on Feb. 10th, 1921, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) General (5 2/ months

CONTRIBUTORY (Secondary) C

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Wm. F. Lecompte M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans.	2/17 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

050945 HEALTH DEPARTMENT—CITY OF BALTIMORE 050945

CERTIFICATE OF DEATH. 14 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 mosher ST. WARD).

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (not named) Infant Miller

(Residence in Baltimore: No. 511 mosher St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
male	col.	Single

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1921 (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 2 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Lee Miller

11-BIRTHPLACE OF FATHER (State or Country). Lexington, Ky.

12-MAIDEN NAME OF MOTHER Cora Bernet

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora miller

(Address) 511 mosher st

15 FEB 17 1921 Filed ..., 191... Burial Permit No. [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 16/21 1921, to ... 191..., that I saw h[illegible] alive on 16/2/1921, and that death occurred, on the date stated above, at 5.40 a.m.

The CAUSE OF DEATH* was as follows:

Insufficient vitality

2 hours

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wilmot Hayes M. D.

16 Feb, 1921 (Address) 421 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mount Auburn Cemetery

DATE OF BURIAL, Feb 17, 191...

20-UNDERTAKER Garrett Goodwin

ADDRESS 142 N. Eutaw St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

050946

HEALTH DEPARTMENT—CITY OF BALTIMORE

050946

CERTIFICATE OF DEATH.

REGISTERED NO. 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 S. Pulaski ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine O'Brien

(a) RESIDENCE. No. 623 S Pulaski ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael J. O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Loftus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. M. J. O'Brien

(Address) 623 S. Pulaski St

15 Filed FEB 17 1921 ROGER J. BRADLEY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 6, 1921, to Feby 15, 1921, that I last saw her alive on Feby 14, 1921, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Wm O'Neill M. D.

2/15, 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 18 1921
20 UNDERTAKER	ADDRESS
John Fields	1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Rheumatism

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2050947 HEALTH DEPARTMENT--CITY OF BALTIMORE 2050947

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 113

CITY OF BALTIMORE (No. 1743 Darley Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Joseph L. Parsons

(Residence in Baltimore: No. 1743 Darley ave St.; 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED (Write the word): widower

6 DATE OF BIRTH: Febry 18, 1844 (Month) (Day) (Year)

7 AGE: 76 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9 BIRTHPLACE (State or country): Kent Co. Md.

PARENTS

10 NAME OF FATHER: John H. Parsons

11 BIRTHPLACE OF FATHER (State or country): Md —

12 MAIDEN NAME OF MOTHER: Delia V. Attwood

13 BIRTHPLACE OF MOTHER (State or country): Kent Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John D. Bowers

(Address) 1743 Darley Ave

15 FEB 17 1921 — ROBERT J. BAUER — Burial Permit Issued — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 16, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1921, to Feb. 16 1921, that I saw him alive on Febry 16, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Gastro enterostomy Hoarseness

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Anaemia (Duration) 2 yrs. mos. ds.

(Signed) [illegible] M. D.

Feb. 16, 1921 (Address) 108 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Middletown Del — DATE OF BURIAL: Feby 17, 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Lafayette

D50448 HEALTH DEPARTMENT—CITY OF BALTIMORE D50448

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 411 N. Monument 11 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franklin Hill

(Residence in Baltimore: No. 411 N. Monument St.; yrs. 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	sing

6-DATE OF BIRTH, Dec. 3, 1918
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Noah S. Hill

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Daisy Knox

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Day

(Address) 413 N. Monument

15- FEB 17 1921 Filed ....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. J. Kenney M. D.
(Coroner.)

Feb 17, 1921 (Address) 2801 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Feb 17th 1920
20-UNDERTAKER Mrs Robt A Elliott	ADDRESS 1720 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-9-19—H. P. Co.—1000 Blks.

D50949 HEALTH DEPARTMENT—CITY OF BALTIMORE D50949

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 N. Fulton Ave ST.: 15 WARD)

2-FULL NAME John M. Rodgers

(a) RESIDENCE. No. 1815 N. Fulton ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza M. Rodgers

6 DATE OF BIRTH (month, day, and year) Sept 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carriage Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fortress Monroe Virginia

PARENTS

10 NAME OF FATHER Mathew Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mattie McAlpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eliza M. Rodgers
(Address) 1815 N. Fulton ave

15 Filed FEB 17 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to July 16, 1921, that I last saw him alive on Nov 20, 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analyses

(Signed) Geo. T. Kemp, M. D.

. 19 (Address) St James apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 18 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W North ave

TION is very important. See instructions on back of certificates. ...it may be properly classified. Exact statement of OCCUPA-

Spec. 6-9-19 H. P. Co. 1000 Blks.

D50950 HEALTH DEPARTMENT—CITY OF BALTIMORE D50950

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Lemmon ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Mc. Geary.

(a) RESIDENCE. No. 916 Lemmon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Mc. Geary

6 DATE OF BIRTH (month, day, and year): Nov. 20th 1854

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work. 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mr. James Mc. Geary (Address) 916 Lemmon St.

15 Filed FEB 17 1921 ROBERT J. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 15. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10th, 1921, to Feb. 15, 1921, that I last saw h— alive on Feb. 15, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical etc.

(Signed) J. Thos. Boston, M. D.

2/16, 1921 (Address) 888 N. Loudon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Feby 18th 1921
20 UNDERTAKER: John J. Cowan & Son	ADDRESS: 907 Hollins St.

THION is very important. See instructions on b... ...ate it may be properly classified. Exact statement of OCCUPA... ...s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

A50951

HEALTH DEPARTMENT—CITY OF BALTIMORE

A50951

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 W Fraul St - St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Loud.

(a) RESIDENCE. No. 1733 W Fraul St - St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of Annie B Loud.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 24

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Frank Loud.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Annie B Loud.
(Address) 1733 W Fraul St -

15 Filed FEB 17 1921 ROBERT L. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to Feb 16, 1921, that I last saw h— alive on Feb 15-21, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Septic Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gross & Physical Exam

(Signed) James H Kelly, M. D.

2/17, 1921 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Feby 19 1921
20 UNDERTAKER	ADDRESS
John J Cowan & Son	907 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

050952

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 050952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Hanover ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Klages

(a) RESIDENCE. No. 1039 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Klages

6 DATE OF BIRTH (month, day, and year): Feb 26 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fred Spatz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Augusta Schloman
(Address) 1039 Hanover St

15 Filed FEB 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1921, to Feb 15 1921, that I last saw her alive on Feb 15 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as ~~follows~~:

Chronic Interstitial Nephritis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Hammond Buckler, M. D.

2/16/1921 (Address) 831 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Feb 18 1921
20 UNDERTAKER	ADDRESS
B. Schloman & Son	Lanvale

IT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bertha Joly.

D50953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1702 D50953

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bertha Joly

(a) RESIDENCE. No. 1147 N. Milton Ave St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexis Joly

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adam Haberer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jack Lewis

(Address): 1411 E Baltimore

15 Filed FEB 17 1921 ROBERT F. KLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1921, to Feb 16, 1921, that I last saw h[illegible] alive on Feb 10 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary exam & Symptoms

(Signed) J. O. Rudolph, M. D.

, 19 (Address) 1411 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Hebrew	2/17 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

THAT it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

10509 54

HEALTH DEPARTMENT—CITY OF BALTIMORE

10509 54

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Emmett & Rosa May

(a) RESIDENCE. No. 527 N Bond St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Emmett May

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Hall

13 BIRTHPLACE OF MOTHER (city or town) Penn
(State or country)

14 Informant Rosa May
(Address) 527 N Bond

15 Filed FEB 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1921, to Feb 14, 1921, that I last saw h[illegible] alive on Feb 14, 1921, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Induced Miscarriage (7 months)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.

2/15, 1921 (Address) 2008 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Feb. 17. 1921
20 UNDERTAKER	ADDRESS
Milton-Davis	403 N Eden St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D50955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50955

CERTIFICATE OF DEATH.

92-079

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 W. Franklin ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace S. Bird

(Residence in Baltimore: No. 1813 W. Franklin St.; 65 yrs. 11 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH March 9th, 1856 (Month) (Day) (Year)

7-AGE, 65 yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothing Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Lemuel Bird

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary Ann Bird

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes S. Bird

(Address) 1813 W. Franklin St

15- FEB 17 1921 ROBERT I. KRAUTER Registrar.

Filed FEB 17 1921 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 16th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 16th 1921, that I saw him alive on Feb 15th 1921, and that death occurred, on the date stated above, at 8.40 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

Unknown (Duration) ... yrs. ... mos. ... ds.

(Signed) Francis S. Hondle M. D.

191... (Address) 2512 Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Davidsonville Md — DATE OF BURIAL, Feb 18 1921

20-UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very necessary to be properly classified. Should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50956. HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D50956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Webster Street WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Brickley

(a) RESIDENCE. No. 1414 Webster ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel W. Brickley

6 DATE OF BIRTH (month, day, and year): July 3 - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Touchton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Alice Winchester

(Address): 1414 Webster

15 Filed [illegible] 19[illegible] ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/16 1921

17 I HEREBY CERTIFY, That I attended deceased from 11/22, 1920, to 2/16, 1921, that I last saw her alive on 2/16, 1921, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Philip S. Fowler, M. D.

2/17, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leming Sun Md

DATE OF BURIAL: 2/17 1921

20 UNDERTAKER: William Cook

ADDRESS: 507 E North.

TION is very important. See instructions on back of ck of certificates. ay be properly classified. Exact statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50957 HEALTH DEPARTMENT—CITY OF BALTIMORE D50957

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 315 S Bentalow ST.: 20 WARD)

2-FULL NAME Charles Henry Klein

(a) RESIDENCE. No. 315 S Bentalow ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 4-12-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 78

(b) General nature of Industry, business, or establishment in which employed (or employer) Electric R. W.

(c) Name of employer United E. R. & Elec Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christian H Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Knoop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rose Klein

(Address) 315 S Bentalow St

15 Filed FEB 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Feb 14, 1921, that I last saw h.. alive on Feb 13, 1921, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) C F Buxton, M. D.

2/15 1921 (Address) 30 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 17 1921
20 UNDERTAKER Leo Schwab & Bro	ADDRESS 1101 Eutaw

How to be very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCC... state

D 50958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 50958

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 584 Presstman St.; 14 WARD)

Registered No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver Johnson

(Residence in Baltimore: No. 584 Presstman St.; 2 yrs., 4 mos. ds.)

PHYSICIANS should state DISEASE CAUSING DEATH as clearly as may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, Nov. 24, 1839
(Month) (Day) (Year)

7-AGE, 84 yrs. 2 mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Teamster

9-BIRTHPLACE, (State or Country), Iowa

PARENTS.

10-NAME OF FATHER, Peter Johnson

11-BIRTHPLACE OF FATHER (State or Country), Missouri

12-MAIDEN NAME OF MOTHER ..... Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Joshua Maxwell
(Informant)

(Address) 584 Presstman

15- FEB 17 1921 ROBERT F. KRAUTER
Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1½ hrs.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. F. Hennessy M. D.
(Coroner.)

Feb 16 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER George H. Hollon ADDRESS 1631 Aliceanna

Spec.—8-24-14—M. & T.—2000 Blks.

WATKINS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50959 64 D50959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1104 Druid Hill Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Watkins

(Residence in Baltimore: No. 1104 Druid Hill Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 1, 1845 (Month) (Day) (Year)

7-AGE, 76 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dennis Simpson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Snowden

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lavinnia Watkins

(Address) 1104 Druid Hill Ave

15- ROBERT B KRAUTER

Filed FEB 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) – 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 6th 1921, to Feb 15 1921, that I saw h-r alive on Feb 14th 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory Hypostatic Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Old Senility

(Duration) yrs. mos. ds.

(Signed) N Bamberger M. D.

Feb 17, 1921 (Address) 354 N Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty DATE OF BURIAL, Feb 18 1921

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D50960 HEALTH DEPARTMENT—CITY OF BALTIMORE D50960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 N. Gilmor ST. 19 WARD) 28

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Crippen

(Residence in Baltimore: No. 523 N. Gilmor St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colrd	Single

6-DATE OF BIRTH, ... June (Month) 4 (Day), 1918 (Year)

7-AGE, 2 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (child) 800

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William L. Crippen

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Agnes Chase

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha Chase

(Address) 523 N. Gilmor St

15-

Filed ..... 101.... MISS E. KRAUSE

FEB 17 1921 Bureau of Vital Statistics Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

Feb 16, 1921 (Address) 280 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn.	Feb 17, 1921
20-UNDERTAKER	ADDRESS
James H Dennis	1303 Presstman St

IMPORTANT. See instructions on back of certificate. Cause of DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

in Sept. 1918, he married Mabel
months, but child gradually became weaker.
Mother died of tuberculosis in April 1919.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1950961 HEALTH DEPARTMENT—CITY OF BALTIMORE 1950961

CERTIFICATE OF DEATH.

REGISTERED NO. 15 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Guy

(a) RESIDENCE. No. 1340 N. Carey st. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Furney Wooten

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Clara Grantham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M. T. H.

15 Filed FEB 17 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1921, to Feb. 15, 1921, that I last saw her alive on Feb. 15, 1921, and that death occurred, on the date stated above, at 9.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) L. Pusey, M. D.

2-15-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Faldsboro, N. Carolina	Feb 18 1921

20 UNDERTAKER James H Dennis

ADDRESS 303 Presstman St

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

Spec. 6-9-19 H. P. Co.—1000 Bks.

D50962 HEALTH DEPARTMENT—CITY OF BALTIMORE D50962

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Bank St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ryta Grabowska

(a) RESIDENCE. NO. 1518 Bank St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Steven Grabowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bertha Szymanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buffalo N York

14 Informant Steven Grabowski
(Address) 1518 Bank St

15 FEB 17 1921 [illegible] REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/15 1921, to 2/16 1921, that I last saw her alive on 2/16 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N V Date of

Was there an autopsy? N V

What test confirmed diagnosis? Sym & Symptoms

(Signed) Thos A Ornbaff, M. D.

(Address) 1623 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 18 1921

20 UNDERTAKER John N Weber ADDRESS 1803 Bank St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...at it may be properly classified. ...in plain terms, so that it ... PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

D. 50963 (Mazra) D. 50963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #16 York St ST.; 22 WARD) REGISTERED No. C 6

2-FULL NAME Rosa Mazra

(Residence in Baltimore: No. #16 York St St.; ..... yrs., ... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, April (Month) 10 (Day), 1915 (Year)

7-AGE, 5 yrs. 10 mos. 6 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Frank Mazra

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Creama

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Mazra

(Address) #16 York St.

15- Filed ..... 191...

Robert P. Harrison, Registrar.

Burial Permit Clerk.

B 17 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-13 1921, to 2-16 1921, that I saw h[illegible] alive on 2-16 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ... yrs. ... mos. 4 ds.

(Signed) J. A. Duncan M. D.

2-17, 1921 (Address) 1604 Fusha ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 2/17/21

20-UNDERTAKER Geo J. Puth ADDRESS 1735 Harford ave

Important. See instructions on back of certificate. Property classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.50964 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50964

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert DeCasquale

(a) RESIDENCE. NO. 911 Rodman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/10/1920

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
—	7	4	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Robert DePasquale

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Eleon Damaso

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Robert DePasquale
(Address) 911 E Madison St

15 Filed 7/19/21 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/1921.

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Feb 16, 1921,

that I last saw him alive on Feb 16, 1921,

and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) Chas O Donovan M. D.

, 19 (Address) 6-E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	2/19 1921
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

at it may be properly classified. Should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 50965 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50965

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4918 Park Heights Ave ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Annie B. Kise

(a) RESIDENCE. NO. 4918 Park Heights Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B. Kise

6 DATE OF BIRTH (month, day, and year) Dec. 20th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greensburg Ind.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clara L. Newton

(Address) 2918 Park Heights Ave

15 Filed 8/7 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1921, to Feb 16th, 1921, that I last saw her alive on Feb 10, 1921, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Seibert, M. D

Feb 16 1921 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood Cem. Wash. D.C.	Feb 19 1921

20 UNDERTAKER Mr. & Mrs. J. W. Tenfelt & Son ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificates.

D.50966 HEALTH DEPARTMENT---CITY OF BALTIMORE D.50966

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 170

CITY OF BALTIMORE: (No. 1807 W. Mulberry St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Marie Clay Howard,

(Residence in Baltimore: No. 1807 W. Mulberry St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widowed

6-DATE OF BIRTH: Nov. (Month) 8th (Day), 1843 (Year)

7-AGE: 77 yrs. 4 mos. 9 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: ———
(b) General nature of industry, business, or establishment in which employed (or employer): ———

9-BIRTHPLACE (State or country): Calvert Co. Maryland

PARENTS

10-NAME OF FATHER: Zachariah Howard.

11-BIRTHPLACE OF FATHER (State or country): Calvert Co. Maryland

12-MAIDEN NAME OF MOTHER: Mary Pratt

13-BIRTHPLACE OF MOTHER (State or country): Calvert Co. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs. N. C. Whatley
Mrs. C. Geo. Mc D

(Address): 1809 W. Mulberry St.

15- Robert P. Harrison REGISTRAR

FEB 17 1921 (Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February (Month) 17th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4th, 1921, to, Feb. 17th 1921, that I saw h[illegible] alive on Feb. 16th 1921, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) unknown yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Charles Getz, M. D.

Feb. 17, 1921 [Address] 1111 W. Baltimore St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Feb. 19, 1921

20-UNDERTAKER: George J. Smith — ADDRESS: 1008 E. Fayette St.

TION is very important. See instructions on back of certificate.

D.50967 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 2017 WARD) REGISTERED NO. C 15-004

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Brooks.

(Residence in Baltimore: No. 2108 Wilkens Ave.)

18 -------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), (Year)

7-AGE, 57 yrs. ------ mos. ------ ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Simon Brooks.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Sarah.-------

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Gerber. (daughter)

(Address) 2108 Wilkens Ave.

15- Filed 8 17 1921, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 16th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental fracture of the skull.
Ran into street car U. Ry. & E. Co.
No. 1004
(Duration).....yrs.....mos....4..ds.

CONTRIBUTORY (Secondary) Paralysis respiratory centres.
(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner.)

Feb, 17.., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Accident Baltimore St. near Fallsway

Former or usual residence February 12th. 1921

19-PLACE OF BURIAL OR REMOVAL, Edgar Washington Road — DATE OF BURIAL, Feb. 17 1921

20-UNDERTAKER Jack Leurs, — ADDRESS 411 E. Balto

IMPORTANT. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50968 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50968

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Essex ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Sheppard

(a) RESIDENCE. No. 2227 Essex ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 26. 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Morris Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary Schatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mary Sheppard
(Address) 2227 Essex St

15 Filed Robert P. Harrison, Registrar

171921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 19..., to Feb 16, 1921, that I last saw h.e alive on Feb 15, 1921, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Nil

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Knox Snyder M. D.

, 19 (Address) 2958 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Feb 18 1921
20 UNDERTAKER Zickler & Zickler	ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

D.50969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 5-91

CITY OF BALTIMORE (No. 522 Eden St. ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Dougherty

(Residence in Baltimore: No. 522 Eden St, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mary

6-DATE OF BIRTH, April 26 (Month) (Day), 1899 (Year)

7-AGE, 5 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER James Dougherty

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Irene Chaplin

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Dougherty

(Address) 522 Eden St

15-

Filed 1921, 191

Robert P. Harrison,
Burial Permit Clerk. Registrar.

B17921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) H. Knox Emily M. D. (Coroner.)

2-17, 1921 (Address) 9 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Feb 19, 1921

20-UNDERTAKER David Easby

ADDRESS 716 Cathedral

IMPORTANT.—THE CERTIFICATE OF DEATH must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.50970 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1614 Allegheny St.: 2 WARD) 151 REGISTERED No. C.....

2-FULL NAME Stanislaw Dubowski

(Residence in Baltimore: No. 1614 Allegheny Av St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 15, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Stanislaw Dubowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Franciska Krupa

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Dubowski

(Address) 1614 Allegheny Av

15- FEB 17 1921 Robert T. Hartlove Registrar.
Special Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) Moderates find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry J. Finney M. D.
(Coroner)

Feb 17, 1921 (Address) 1614 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem.	Feb. 17, 1921

20-UNDERTAKER Jacot & Falkowski ADDRESS 428 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mary R

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-50971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-50971

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2327 N. Calvert ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Ryan

(a) RESIDENCE. No. 2327 N Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Philip Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Della Rice

(Address) 3500 Greenmeade Ave

15 Filed FEB 17 1921 16 Robert L. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16 1921

17

I HEREBY CERTIFY, That I attended deceased from February 15 1921, to February 16 1921,

that I last saw h.w alive on Feb 15 1921,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) G. W. T Bishop, M. D.

19 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W Pratt

Be sure every item is properly classified. Exact statement of OCCUPATION should state whether employer, employee, or self-employed. Omissions, so that it may be complete as very important. See instructions on back of certificates.

D. 50972 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 50972

CERTIFICATE OF DEATH. 159

1-PLACE OF DEATH Pronounced dead at
CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 15 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward T. King

(Residence in Baltimore: No. 3000 W North ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, ... unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, ..25.. yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Expert Accountant
(b) General nature of industry, business, or establishment in which employed (or employer)..... self

9-BIRTHPLACE, (State or Country), Balto. City, Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Whitehead

(Address) 3000 W North ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) ..16.. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From Shot Wound
Brain Self Inflicted
Suicide

(Duration) ..... yrs. few minutes mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Feb 17, 1921 (Address) 102 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	Feb 17, 1921

20-UNDERTAKER Wm F Cook ADDRESS 1827 W North Ave

DEATHS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50973

CERTIFICATE OF DEATH.

91-068

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 2 WARD)

2-FULL NAME Mary Jubb

(a) RESIDENCE. No. 254 S. Chapel St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Runsheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed 2/16/21 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 4, 1921, to February 15 1921, that I last saw h er alive on February 15, 1921, and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

Toxic psychosis.
(Cause undetermined)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) B Herman., M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Feb 19 1921
20 UNDERTAKER Lilly & Zulu	ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...if may be properly classified. ...should state ...on plain terms, so that it m...

D.50974 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1319 N. Calhoun ST.: 15 150 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Nelson

(Residence in Baltimore: No. 1319 N. Calhoun St.; yrs., 3 hrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	Single

6-DATE OF BIRTH, Feb. 14, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 3 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....None.....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. Frank Nelson

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Nelson

(Address) 1319 N. Calhoun St

15-

Filed ..... 191.... Robert P. Harrison, Registrar.

B 17192

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Contusion of frontal lobe of brain

3 hrs.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Jos. Kennedy M. D.
(Coroner.)

Feb. 14, 1921 (Address) 2802 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Md. DATE OF BURIAL, Feb 18, 21

20-UNDERTAKER Barnes & Wright ADDRESS 1364 W. Fay

IMPORTANT.—DEATH must be reported within 24 hours. Blanks must be filled EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50975 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50975

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Timmons

(a) RESIDENCE. NO. Preston & Valley Sts ST., WARD.
(Usual place of abode) (If nonresidents give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? All yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Timmons.

6 DATE OF BIRTH (month, day, and year) 1 Jan. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home. Ind

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard Noël

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Fleshman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Sister Florence
(Address) Little Sisters of the Poor

15 Filed 1 7 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from to record, 19, that I last saw her alive on July 16, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Arthritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July (Signed) H. A. Warner, M. D.
16, 1921 (Address) 1132 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md.	Feb 18 1921
20 UNDERTAKER William Cook	ADDRESS 532 E. Hoffman Ave

TION is very important. See instructions on back of certificates.

...t may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50976 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50976

CERTIFICATE OF DEATH.

92-010

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 622 Wyanoke ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genera Roberta Stifler

(a) RESIDENCE. No. 622 Wyanoke ST., WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert Stifler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Millerville Md

12 MAIDEN NAME OF MOTHER Sadie Mohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Millerville Iowa

14 Informant (Address) Robert Stifler 622 Wyanoke ave

15 Filed FEB 17 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Feb 16 1921, that I last saw her alive on Feb 16 1921, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Septic pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Probably influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm Stifler, M. D.

Feb 16 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb. 18 1921
20 UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

B 171921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

D.50977 HEALTH DEPARTMENT—CITY OF BALTIMORE D.50977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Western Md. R.R. Tracks near Liberty Heights Ave. REGISTERED No. C 175-003

CITY OF BALTIMORE (No. ..... ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F Burner

(Residence in Baltimore: No. 2316 Ruskin Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Aug 15, 1860 (Month) (Day) (Year)

7-AGE, 60 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Work R.R.

9-BIRTHPLACE, (State or Country), Newark Ohio

PARENTS.

10-NAME OF FATHER, J. V. Burner

11-BIRTHPLACE OF FATHER (State or Country) Newark Ohio

12-MAIDEN NAME OF MOTHER, Christina Flennery

13-BIRTHPLACE OF MOTHER (State or Country), Newark Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Bell Burner

(Address) 2316 Ruskin Ave

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

FEB 17 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry. (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... Jury ..... find that said deceased came to ..... his ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed skull, R.R. accident Western Md. R.R. Near Liberty Heights Ave

Instantly dead Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Unavoidable accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Feb 17, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Liberty Heights Ave (near)

Former or usual residence 2316 Ruskin Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Newark, Ohio	....., 19...
20-UNDERTAKER	ADDRESS
W. Eckmeyer	Fulton Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.50978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.50978

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2217 Jefferson ST.: 6 WARD)

2-FULL NAME ~~2217~~ Wm H. Kernan

(a) RESIDENCE. No. 2217 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marianna Kernan

6 DATE OF BIRTH (month, day, and year) July 2 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm H Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Katherine Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Wm C Kernan
(Address) 2217 Jefferson

15 Filed 3 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Feb 17, 1924, that I last saw h.. alive on Feb 16, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Carr, M. D.

(Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 19 1924
20 UNDERTAKER	ADDRESS
Wm Cook	N & S Mkt

PHYSICIANS should state plainly in ink and CAPITALS EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50979 HEALTH DEPARTMENT—CITY OF BALTIMORE D50979

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2796½ Tivoly Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard A. Shook

(a) RESIDENCE. No. 2796 Tivoly Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Shook

6 DATE OF BIRTH (month, day, and year) June 10, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Bank 039

(c) Name of employer Commerical Bank

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Shook

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Catherine Plowman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Margaret Shook
(Address) 2796 Tivoly Ave

15 Filed FEB 18 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1921

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1920, to Feb. 16, 1921

that I last saw h[illegible] alive on Feb. 14, 1921.

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about 2 yrs.
(duration)

CONTRIBUTORY ✓
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) Geo. Heller, M. D.

3-16-1921 (Address) 1937 Joseph St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Feb. 18 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Eastern Ave.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

k50980

HEALTH DEPARTMENT—CITY OF BALTIMORE

k50980

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard E. Green

(a) RESIDENCE. No. 425 S. 12th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Riverter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Minnesota.
(State or country)

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Jones

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed FEB 18 1921 ROBERT J. BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 12, 1921, to February 13, 1921 that I last saw him alive on February 13, 1921 and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) Patterman, M. D.

2/14/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	2/17 1921
20 UNDERTAKER Commissioner Health,	ADDRESS

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement of OCCUPA-

DEATH in plain terms, so that

Body removed to Morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 D50981

REGISTERED No. C 28 D50981

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 408 N Fremont St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Robinson

(Residence in Baltimore: No. 408 N Fremont St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Don't Know

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
38 about yrs. mos. ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0 do

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- FEB 18 1921

Filed ..... 191.... ROBERT J. BREUTER Registrar.

Burial Permit Given

Morgue

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~Coroner~~ au- ~~Autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Don't Know

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Tormey M. D. (Coroner.)

2-15, 1921 (Address) 117 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	2-16, 1921

20-UNDERTAKER	ADDRESS
Commissioner Health.	

For Wm. H. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L 50982

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 50982

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 913 Walnut ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Mays

(Residence in Baltimore: No. 913 Walnut St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Negro	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, ... yrs. one mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Jesse Mays

11-BIRTHPLACE OF FATHER (State or Country). Alabama

12-MAIDEN NAME OF MOTHER Josephine Roby

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Mays Pd

(Address) 913 Walnut St

15-

Filed FEB 18 1921, 191.....

ROBERT F. KRAUTER

Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Theodore Schley M. D.
(Coroner.)

Feb 15 191... (Address) 1600 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health,

ADDRESS FEB 16 1921

Per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Infant Wertzer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50983 ✓ D50983

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 Penna Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME None-Lived only 2 hours!

(Residence in Baltimore: No. 2811 Penna. Ave. St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, White | 5-SINGLE, ~~MARRIED,~~ WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 2- (Month) 16th (Day), 1921 (Year)

7-AGE, 2 hours ~~yrs.~~ ~~mos.~~ ~~ds.~~ | If LESS than 1 day, ~~hrs.~~ or ~~min.~~?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... X
(b) General nature of industry, business, or establishment in which employed (or employer)..... X

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Bernard F. Wertzer

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Bell.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. F. Wertzer

(Address) 2818 Penna Ave

15-

Filed FEB 18 1921, 191... SIDNEY B. KRAUTER

Burial Permit ~~filed~~ issued.

JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby. (Month) 16th (Day), 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Feby 16th 1921, ~~to~~ ~~191~~, that I saw him alive on 2-16th 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows: Tobe determined. Child was in utero about first 8 mos. Self vomiting. Lived about 2 hrs after birth.

(Duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

CONTRIBUTORY (Secondary) X

(Duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

(Signed) W. H. Wolff M. D.

2-16-, 1921 (Address) 1100 N. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL | DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health, | ADDRESS FEB 16 1921

Per. Wm. E. WOODALL.

Important. See instructions on back of certificate. ... PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

A50984

HEALTH DEPARTMENT—CITY OF BALTIMORE

A50984

CERTIFICATE OF DEATH.

18

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rayman (Kirby

(a) RESIDENCE. No. Florence Britton Home ST. ..... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Lucile Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant J. H. Hosp. records
(Address)

15 Filed FEB 18 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to Feb 11, 1921, that I last saw h[illegible] alive on Feb 11, 1921, and that death occurred, on the date stated above, at 10 09 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. — mos. 6 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Ward address

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? None

(Signed) W Barton, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	FEB 16 1921

20 UNDERTAKER Commissioner Health.
ADDRESS

Rev. Wm. E. Woodall

PHYSICIANS should state DISEASE EXACTLY. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

050985 HEALTH DEPARTMENT—CITY OF BALTIMORE 050985

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 Kate ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Hoffman

(Residence in Baltimore: No. 2630 Kate ave St.; Life yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 27th, 1839 (Month) (Day) (Year)

7-AGE, 81 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City Md

PARENTS.

10-NAME OF FATHER, George L. Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md

12-MAIDEN NAME OF MOTHER Mary D. Kyle

13-BIRTHPLACE OF MOTHER (State or Country), Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Hoffman

(Address) 707 N. Eutaw St Balto City Md

15- FEB 18 1921 ROBERT P. LAUTER

Filed....., 191.... Registrar

Burial P...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Feb 15 1921, that I saw him alive on Feb 14 1921, and that death occurred, on the date stated above, at 5.10 p m.

The CAUSE OF DEATH* was as follows:

Sclerosis (Obstruction) Jaundice

(Duration) — yrs. — mos. 46 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) John D. Young M. D.

Feb 16, 1921 (Address) 1425 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Feb 18, 1921

20-UNDERTAKER N M Routson — ADDRESS 2238 N Smith

IMPORTANT: PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1950986

HEALTH DEPARTMENT—CITY OF BALTIMORE

1950986

CERTIFICATE OF DEATH.

1540-04

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Ginsberg

(Residence in Baltimore: No. 3001 Garrison Ave St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 17 (Day) 1868 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clothing
(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Joseph Ginsberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER ~~Joseph~~ Bessie Hop

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- FEB 18 1921 ROBERT E KRAUTER

Filed....., 191.....

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-27 1921, to 2-17 1921, that I saw him alive on Feb 17 1921, and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, R.L.

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY. Bronchial Pneumonia

(Secondary) Pneumonia (Duration) .....yrs. .....mos. 1 .....ds.

(Signed) Nathan J Hanover M. D.

2-17, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 21 ds. In the State 35 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 3001 Garrison Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Feb. 19, 1921

20-UNDERTAKER Jack Lewis — ADDRESS, 1411 E. Balto

important. See instructions on back of certificate.

Form 6-9-19—H. P. Co.—1000 Blks.

D50987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50987

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Hull St.; WARD 24)

2-FULL NAME James Joseph McHale

(a) RESIDENCE. No. 1419 Hull St., WARD 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	15	12 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakesman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Balto & Ohio R.R. Co

9 BIRTHPLACE (city or town) (State or country) Osceola Mills Clearfield Co. Pa.

PARENTS

10 NAME OF FATHER Michael McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland

14 Informant Annie McHale

(Address) 1419 Hull St.

15 FILED FEB 18 1921 BOLER E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1921, to Feb 16 1921, that I last saw him alive on Feb 16 1921, and that death occurred, on the date stated above, at 12 15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cancer of Liver

Failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. D. Hayward, M. D.

(Address) 423 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Feb 19 21
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1427 Eighth St.

NOTE—Is very important. See instructions on back of certificates. [illegible] may be properly classified. Exact statement of OCCUPATIONS should state

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

250988 250988

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 Bricklead St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Charles Ruffer

(a) RESIDENCE. No. 33 Brocklead St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Ruffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant (Address) John Ruffer 33 Brocklead St

15 Filed FEB 18 1921 Burial Permit Issued Recorded

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb 17, 1921, that I last saw him alive on Feb 17, 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital weakness due to premature birth - about 7½ mos gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & appearance

(Signed) Wm L Stiller, M. D.

2/18, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: Feb. 18 1921

20 UNDERTAKER: Margaret G. Flynn

ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50989 HEALTH DEPARTMENT—CITY OF BALTIMORE V 50989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1952 W. Mulberry St. St. 20 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred A. King.

(a) RESIDENCE. No. 1952 W. Mulberry St. Ward.

(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. King.

6 DATE OF BIRTH (month, day, and year) Aug 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Timothy Cloonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Katherine Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Charlotte Stout, (Address) 1952 W. Mulberry St.

15 Filed FEB 18 1921 Robert F. Leuthe Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-1921

17 I HEREBY CERTIFY, That I attended deceased from 9-1- 1920, to 2-16- 1921, that I last saw her alive on 2-15- 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (face) Small cell

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Systemic debility induced by above

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. Perrow, M. D.

2-17-1921 (Address) 2202 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Feb. 19 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 14 N Eighth St.

ATION is very important. See instructions on back of certificates. Exact statement of OCCUPA- PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50990

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Rose ST.; 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Hopkins

(a) RESIDENCE. NO. 403 Rose St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Henrietta Hopkins

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Md

PARENTS

10 NAME OF FATHER Benjamin Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co.

12 MAIDEN NAME OF MOTHER Rosetta Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co

14 Informant Mrs Henrietta Hopkins (Address) 403 Rose St.

15 Filed FEB 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 15, 1921, that I last saw him alive on July 15, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

a Cardiac Dilatation.

Probably Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. A. Smith, M. D.

. 19 (Address) 109 N. Law St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Feb. 18 1921
20 UNDERTAKER	ADDRESS
Wm. G. Locke	1302 Jeffer

TION is very important. See instructions on back of certificates. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA- in plain terms, so that it m

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer—Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatism

Spec.—6-9-19—H. P. Co.—1000 Bks.

D50991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 110 N. Vincient St ST.: 19 WARD)

2-FULL NAME Rachel Johnson

(a) RESIDENCE. No. 110 N. Vincient St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henson Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Worked at home

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Annie Arundel Co.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth Johnson (Daughter)

(Address) 110 N. Vincient St.

15 Filed ....., 19 ..... ROBERT I. CHAUTER Registrar

FEB 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15/'21 19

17

I HEREBY CERTIFY, That I attended deceased from Feb. 7th. 1921 19 to Feb. 15th 1921 19, that I last saw her alive on Feb. 15th. 1921 19, and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis (Septic)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer Perforated

(duration) 1 yrs. 6? mos. ds.

18 Where was disease contracted if not at place of death? Pats. Res.

Did an operation precede death? No! Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam.

(Signed) Walter S. Jackson, M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Zion Cem. Feb. 18th 1921

20 UNDERTAKER — ADDRESS

A. Jones 207 S. Shuter St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50992

CERTIFICATE OF DEATH.

D 50992

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Perry.

(a) RESIDENCE. No. 817 Bell. Stret ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Webb Perry.

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Minnie Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jenkins

14 Informant (Address) J. Hopkins Hosp. records

15 Filed FEB 18 1921 19 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 15. , 1921, to Feb. 17. , 1921, that I last saw h im alive on Feb. 17. , 1921, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) W. C. Davison, M. D.

Feb. 17, 1921 (Address) J. H. H. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	2/19 1921
20 UNDERTAKER	**ADDRESS**
John J. Cowan	601 Hollins St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-
it may be properly classified. PHYSICIAN should state
on parts of this, so that

Spec.– 6-9-15– H. P. Co.– 1000 Blks.

D 50993 Patrick Krealy D 50993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2342 W Fayette ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Krealey

(a) RESIDENCE. No. 2342 W Fayette ST. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Lina Krealey

6 DATE OF BIRTH (month, day, and year) Sept – 1868

7 AGE 52 Years	Months [illegible]	Days 27	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman 61

(b) General nature of industry, business, or establishment in which employed (or employer) Western Dist.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Krealey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Lina V. Kreagly
(Address) 2342 W. Fayette St

15 Filed FEB 16 1921 19 ROBERT B. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 22 -, 1920, to 2. 15 -, 1921.

that I last saw h alive on 2-15-, 1921,

and that death occurred, on the date stated above, at 630 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
Uremic Coma

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

, 19 (Address) Halethorp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb. 18 1921
20 UNDERTAKER	ADDRESS
Geo. E. Schwab & Bro	2101 Eutaw ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

SADLER

HEALTH DEPARTMENT—CITY OF BALTIMORE

L50994 L50994

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Eutaw Place ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosabella Cooper Sadler

(a) RESIDENCE. NO. 1421 Eutaw Pl. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E. Sadler

6 DATE OF BIRTH (month, day, and year) June 15th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry W. Slicer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Virginia

12 MAIDEN NAME OF MOTHER Rosabella Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Henrietta W. Slicer

(Address) 1421 Eutaw Place

15 FEB 18 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1919, to Feb 18, 1921, that I last saw her alive on Feb 18, 1921, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Operated on as Enchondroma of rib followed by involvement of Vertebra & femur

(duration) 1 yrs. 7 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 4th 1919

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. E. Sadler, M. D.

19 (Address) 1421 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	2-19- 1921
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	Mitchell & Eastwood

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 50995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 509 E Fortune ST.: 24 WARD)

2-FULL NAME James N. Saffield

(a) RESIDENCE. No. 509 E Fortune ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Mollie Saffield

6 DATE OF BIRTH (month, day, and year) Feb. 17 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Last or National Enameling & Stamping Co

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Charles Saffield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Arnold Md

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Arnold Md

14 Informant Wm. Saffield
(Address) 509 E Fortune ave

15 FILED FEB 18 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Feb 16, 1921, that I last saw him alive on Feb 16, 1921, and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos E Stiles M. D.

2/16 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dumbarton Mill	2/18 1921
20 UNDERTAKER	ADDRESS
Sam'l F. Staley & Sons	13 E Lexington

1

TION is very important. See instructions on back of certificates.

...at it may be properly classified. Exact statement ... Occupation ...

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 50996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50996

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 W. North Ave ST.: 14 WARD)

2-FULL NAME Bettie Schneider

(a) RESIDENCE. NO. 900 W North Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Schneider

6 DATE OF BIRTH (month, day, and year) April 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Roth
(Address) 905 Ashland

15 Filed ..... 19 ..... Register.

FEB 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15th 1921 to Feb 17th 1921 that I last saw h[illegible] alive on Feb 17th 1921 and that death occurred, on the date stated above, at 9.10A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. H. Kellyman M. D.

Feb 18 1921 (Address) 1721 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cemetery	Feb 18th 1921

20 UNDERTAKER Harold Southerman ADDRESS 1618 W Lafayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

JONES

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50998

D 50998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 202 Hilton Road near Gwynn Oak Ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace E. Jones

(a) RESIDENCE. No. 202 Hilton Road St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3/4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Maryland

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pikesville Maryland

14 Informant John Jones
(Address) 202 Hilton Road

15 Filed ... 19 ... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1921, to Feb 17, 1921, that I last saw h.. alive on Feb 17, 1921, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Claud Jones, M. D.

2/18, 19 21 (Address) 4706 - Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cemetery	Feb. 19th 1921
20 UNDERTAKER	ADDRESS
Frank Lacasha Sons	Fullerton Md.

DEATHS—CITY OF BALTIMORE. PHYSICIANS should state plainly that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D50998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D50998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 516 Robert St., St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Carr

(Residence in Baltimore: No. 516 Robert St.; St.; Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Oct 20th, 1876 (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 3 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Alexander Carr

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Harris

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Richard Carr

(Address) 516 Robert St

15- Filed FEB 18 1921 BOARD OF HEALTH Burial Permit No.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 16th, 1921 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 18th, 1921 191, to Feb 16th, 1921 191, that I saw h... alive on Feb 16th, 1921 191, and that death occurred, on the date stated above, at 6:15P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

2/17/21, 191... (Address) 1500 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, In D Auburn Cem DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER George W. Holland ADDRESS 631 Druid Hill Ave

Important. See instructions on back of certificate. Names of PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 50999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 50999

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 934 S Paca ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olva Irene Joyce

(a) RESIDENCE. No. 934 S Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 26 1900

7 AGE — Years: 20 — Months: 5 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Franklin Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Rinehardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Franklin Joyce
(Address) 934 S Paca

15 Filed FEB 18 1921 ROBERT J. KRAUTER Registrar
Burial Permit 6104

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1921

17 I HEREBY CERTIFY, That I attended deceased from ——, 192—, to Feb 17, 1921, that I last saw h— alive on Feb 15, 1921, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Joyce, M. D.

(Address) 934 S Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 21 1921

20 UNDERTAKER: H. Thumm Sons — ADDRESS: Baltimore

IMPORTANT.—Items of information required on this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51000

HEALTH DEPARTMENT—CITY OF BALTIMORE

105000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2932 N. Calvert ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Witwright White

(a) RESIDENCE. No. 2932 N Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur C. White

6 DATE OF BIRTH (month, day, and year) Sept 23 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A.G. Co Md.

PARENTS

10 NAME OF FATHER Philip Witwright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eleanor Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Lulia White Krapick (Address) Pikesville Md

15 FEB 18 1921 ERNEST J. KRAUTER Registrar Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1921, to Feb 15 1921, that I last saw h alive on Feb 15 1921, and that death occurred, on the date stated above, at 6.20 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

do not know

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis do not know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? signs

(Signed) R L Rupert, M. D.

, 19 (Address) Walkworth apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	2/19/21
20 UNDERTAKER	ADDRESS
Wm J Tichnor Sons	North Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D51001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 E-32' St 19 74 Ward)

REGISTERED NO....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Walter

(a) RESIDENCE. No. 105 E. 32' St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Walter

6 DATE OF BIRTH (month, day, and year) Nov 10 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Frolich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Walter
(Address) 105 E 32nd St.

15 Filed FEB 18 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Feb 17, 1921, that I last saw h.. alive on Feb 16, 1921, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Cardiac dilatation

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) C Urban Smith, M. D.

, 19 (Address) 817 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 19 19
20 UNDERTAKER	ADDRESS
H. Thurnwald Son	Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51002 D51002

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Presbury ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Engle

(Residence in Baltimore: No. 2500 Presbury, So St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Feb 1 (Month) (Day), 1 (Year)

7-AGE, ...yrs.....mos.....ds.

If LESS than 1 day, 49 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Paul W. Engle

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Anna Zittle

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. W. Engle

(Address) 2500 Presbury St

FEB 13 1921

15-

ROBERT J. KRAUTER

Filed....., 191.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18 (Month) (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 17 1921, to Feb 18 1921, that I saw him alive on Feb 17 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Undeveloped —

(Mother is advanced case of Tuberculosis)

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Undeveloped

..... (Duration).....yrs.....mos.....ds.

(Signed) W. S. Tublitz M. D.

Feb 19 24, 191... (Address) 2000 Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Westen Cem't — DATE OF BURIAL, Feb 18, 1921

20-UNDERTAKER Wm Bal 502 E Balto — ADDRESS

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51003

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2669 Frederick Ave. ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Trogler

(a) RESIDENCE. No. 2669 Frederick Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Trogler

6 DATE OF BIRTH (month, day, and year) Apr. 26 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Drover of Cattle for

(b) General nature of industry, business, or establishment in which employed (or employer) Corkran Hill Co.

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant. Mrs. Mary Trogler
(Address) 2669 Frederick Ave.

15 Filed FEB 18 1921 ROBERT F. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Feb 16, 1921, that I last saw h[e] alive on Feb 16, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. A. Kuehl, M. D.

2/16, 1921 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 19 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 51004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1004 S. Eutaw St. ST.: 21 WARD)

REGISTERED No. C. 158

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Bonns. (C)

(Residence in Baltimore: No. 1004 S. Eutaw St. St.; yrs., 3 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single.

6-DATE OF BIRTH, November 9th. 1920, / (Month) (Day) (Year)

7-AGE, ---yrs. 3 mos. 8 ds. If LESS than 1 day, ---hrs. or---min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Bonns. (C)

11-BIRTHPLACE OF FATHER (State or Country), North Carolina.

12-MAIDEN NAME OF MOTHER, Ethel Cornish. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Bonns. (C) mother.

(Address) 1004 S. Eutaw St.

15-

Filed ....., 191.... Robert F. Harrison, Registrar.

Burial Permit Clerk.

18 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 17th. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency. congenital.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Feb 18, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn ct | DATE OF BURIAL, Feb 18, 1921

20-UNDERTAKER J. L. & J. Bromwell Son | ADDRESS 101 W. Monty st

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state impertant. See instructions on back of certificate. OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51005

CERTIFICATE OF DEATH.

X 97-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abr Rutgerson

(a) RESIDENCE. No. Belair Road ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs mos. da

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unk

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unk

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68,			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unk
(State or country)

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Robert T. Harrison, Registrar
181921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to Feb 14, 1921, that I last saw him alive on Feb 14, 1921, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Double Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank C. Marcus, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 2/17 1921

20 UNDERTAKER Commissioner Health,

ADDRESS E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.51006 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51006

CERTIFICATE OF DEATH. +1

1-PLACE OF DEATH S. Balto. Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (NO. 1600 N. Wolfe ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Uttg.

(a) RESIDENCE. NO. 1600 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 29 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER August Rochlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Gtschner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Mrs Geo A Klyelin [illegible] Harrison,

15 Filed [illegible], 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1921, to Feb. 17, 1921, that I last saw h[illegible] alive on Feb 17, 1921, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of transverse colon

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 7, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Co Sobihal, M. D.

, 19 (Address) S. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Feb 19 1921
20 UNDERTAKER	ADDRESS
John Henry & Co	208 Orleans

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N Rose St.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch L. Porter

(a) RESIDENCE. No. 504 N Rose St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Eisenhauer

6 DATE OF BIRTH (month, day, and year) Jan 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md
(State or country)

PARENTS

10 NAME OF FATHER John Porter

11 BIRTHPLACE OF FATHER (city or town) Frederick Md
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Mary Porter
(Address) 504 N Rose St

15 Filed Feb 18 1921 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-14-21, 19..., to 2-17-21, 19...,
that I last saw alive on 2-17-21, 19...,
and that death occurred, on the date stated above, at 12- m.
The CAUSE OF DEATH* was as follows:

Hypostatic

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Seymour, M. D.
2-18-21, 19 (Address) 2528 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	Feby 19 1921
20 UNDERTAKER J Henkel & Co	ADDRESS 2008 Aliceanna

MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51008

92085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1564 Carswell ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bahnline

(a) RESIDENCE. No. 1564 Carswell ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo D. Bahnline

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Patrick Lamil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Geo D. Bahnline

(Address) 1564 Carswell St

15 Filed Robert P. Harrison, Registrar

B 181921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby. 12, 1921, to Feby. 16, 1921, that I last saw her alive on Feby. 15, 1921, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Heart Block.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonitis.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Wm J. Dillsbury, M. D.

, 19 (Address) 602 E. 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	2.9 19 21

20 UNDERTAKER ADDRESS

J. D. Evans & Son 118 W. Mt Royal Av

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51009

CERTIFICATE OF DEATH.

14

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hosp't ST.; 6 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Moran

(a) RESIDENCE. No. 237 N. Kenwood Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Patrick J Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Kath E Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Patrick J Moran

(Address) 237 N. Kenwood Ave

15 Filed ..... 19 Robert F. Harrison, Registrar

FEB 18 1921

[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1921 to February 17 1921.

That I last saw her alive on Feb 17 1921, and that death occurred, on the date stated above, at 9 P. ..m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Amoebic dysentery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What confirmed diagnosis? Microscopic Exam

(Signed) A Stoll Jr, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	2-20 1921
20 UNDERTAKER J G Moran	ADDRESS 3xx E Broadway

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.51010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 W. Lafayette ave ST.; 6 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Connors

(a) RESIDENCE. No. 131 W. Lafayette ave ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Connors

6 DATE OF BIRTH (month, day, and year) Apr-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Ingon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dorothy Ingon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs James Mc Grath (Address) 131 W. Lafayette ave.

15 Filed FEB 18 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1921 to Feb 16 1921 that I last saw h[illegible] alive on Feb 16 1921 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. O'Regan M. D.

2/18 1924 (Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jew Cathedral Cem	2-17 19 21
20 UNDERTAKER J. G. Moran	ADDRESS E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Elizabeths Home

REGISTERED NO. C 37

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth R. Saunders.

(Residence in Baltimore: No. St Elizabeths Home St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	

6-DATE OF BIRTH, June (Month) 2 (Day) 1918 (Year)

7-AGE, 2 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), City charge - entered April 2/20
History of parents ~~is~~ not obtained

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JOHNS HOPKINS HOSPITAL.

Filed ....., 191...

84021 Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1920, to Feb 15 1921, that I saw h er alive on Feb 15 1921, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

.....
Tuberculosis Pulmonis
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probable Lues. (No Wassermann)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Francis J Ayd M. D.

Feb 18, 1921. (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health.

ADDRESS FEB 18 1921

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very necessary to be properly classified. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51012

CERTIFICATE OF DEATH.

91-084

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 Reynold, St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam S. Lesniewski

(a) RESIDENCE. No. 1332 Reynold. St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 20-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Lesniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helena Czyszewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Lesniewski
(Address) 1332 Reynold.

15 Filed Feb 18 1921 Robert P. Harrison, Registrar

EB181921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb. 17, 1921, that I last saw him alive on ....., 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Freedom M. D.

2/18, 1921 (Address) 918 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb. 21 1921
20 UNDERTAKER	ADDRESS
Kirkwood	68 Fawkes Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 51013 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1204 n mullen St. 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elzobieta Cpalecky

(Residence in Baltimore: No. 1204 n mullen St.; yrs., 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. ..... Nov. 8 ..... (Month) ..... 1 ..... (Day) ..... (Year)

7-AGE. 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Karel Svoboda

11-BIRTHPLACE OF FATHER (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Emma Vojek

13-BIRTHPLACE OF MOTHER (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chalecky

(Address) 1204 N Mulberry

15-

FEB 18 1921 (Filed), 191. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) ..... 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Leo Hartman M.D.
(Coroner.)

2-17-21, 191., (Address) 4 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Feb 19, 1921

20-UNDERTAKER Grant Gorsuch & Son — ADDRESS 1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

20.51014

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guia Winiefski

(a) RESIDENCE. No. 25 Church St. Curtis Bay WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20-'16

7 AGE — Years: 4 — Months: 10 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Emil Winiefski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Emilia Cilinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant Emil Winiefski
(Address) 25 Church St

15 Filed 19 Robert P. Harrison, Registrar

B181921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1921, to Feb. 17, 1921, that I last saw her alive on Feb. 17, 1921, and that death occurred, on the date stated above, at 8:35 P m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. MacGowan, M. D.

2/18/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Ca — DATE OF BURIAL: Feb 18 1921

20 UNDERTAKER: Frank Brach Son — ADDRESS: 1706 Bolton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baytime Hospital

CITY OF BALTIMORE: No. 76 ST. 79 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Sutton

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 67. Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Baytime Hosp. Balto. Md.

15 Filed Burial Permit Clerk. Registrar

Robert P. Harrison.

B181921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1921, to Feb. 17, 1921, that I last saw him alive on Feb. 16, 1921, and that death occurred, on the date stated above, at 1000a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Deterioration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldsmith M. D.

2/17/1921 (Address) Baytime Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL	FEB 19 1921

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. —6-9-19—H. P. Co.— 1000 Bks.

D.51016 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51016

CERTIFICATE OF DEATH

1-PLACE OF DEATH St. Joseph's Hospital 350

CITY OF BALTIMORE: (NO. ..... ST.: 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Petronella Mazilewky

(a) RESIDENCE. NO. 112 Albemarle ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 21 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mokow

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE 37 Years — Months — Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Joseph Ramelis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Mokow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: J. Mazilewsky (Address) 112 Albemarle St

15 Filed 1 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1921, to Feb. 17, 1921, that I last saw her alive on Feb. 17, 1921, and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Ulcerated Carcinoma

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes - Acetonuria

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + urinalysis

(Signed) F. C. Marino, M. D.

2-11-21 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislovas	Feb 21 1921
20 UNDERTAKER	**ADDRESS**
John Grebliunas	425 S. Pac,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51017

CERTIFICATE OF DEATH.

53

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Rose St.; 1st WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Niedenhofer

(Residence in Baltimore: No. 514 S. Rose St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. 29, 1868.
(Month) (Day) (Year)

7-AGE, 53 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Niedenhofer.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wilhemina Caspar.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bertha Niedenhoff

(Address) 514 S. Rose St.

15-

FEB 18 1921

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to Feb. 1921, that I saw him alive on Feb. 16, 1921, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

..... (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

..... (Duration) 1 yrs. 5 mos. ds.

(Signed) Herman L. Gilmes M. D.

Feb. 17, 1921. (Address) 1900 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Peter Nicolaus — DATE OF BURIAL, Feb. 20., 1921.

20-UNDERTAKER 1st. Evang. German Cem. — ADDRESS 2046 Eastern Ave.
Local

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important, so that it may be properly classified. PHYSICIANS should state plain terms, so that it may be properly

Spec.—8-24-14—M. & T.—2000 Blks.

D.51018 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51018

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 Boston ST.; 1 WARD) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olga Kowalewich

(Residence in Baltimore: No. 2230 Boston St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
F	W	S

6-DATE OF BIRTH, Dec. 17, (Month) (Day) 1920 (Year)

7-AGE,	If LESS than 1 day,
yrs. 2 mos. 1 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Anfelafe Kowalewich

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dominika Kowalewich

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Kwiatkowski

(Address) 2320 Boston St.

15-

Filed FEB 9 1921, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 18, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 16 1921, to Feb. 18 1921, that I saw h[illegible] alive on " 16 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Chas Duer M. D.

2/19/21, 191... (Address) 408 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
Holy Redeemer	Feb. 17, 191
20-UNDERTAKER	ADDRESS
John Grabiniecki	425 S. Para

IMPORTANT. See instructions on back of certificate. Every question on this certificate must be answered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8th DAY December OF 1964 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH #D 48216 Nov. 20, 1920 AND ENDING WITH #D 51018 Feb 19, 1921 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: D. McFaul

END OF REEL